

Highly Confidential - Todd Cameron

1 THE STATE OF MONTANA
OFFICE OF THE ATTORNEY GENERAL
2 OFFICE OF CONSUMER PROTECTION

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5 SEPTEMBER 26, 2018

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8
9 Oral testimony of TODD CAMERON, taken
10 pursuant to notice, was held at the law offices of
11 Baker & Hostetler, LLP, 250 South Civic Center Drive,
12 Suite 1200, Columbus, Ohio 43215, commencing at 10:23
13 a.m., on the above date, before Carol A. Kirk, a
14 Registered Merit Reporter.

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1 DEPOSITION OF TODD CAMERON

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1 P R O C E E D I N G S

2 - - -

3 MS. SINGER: This is Linda Singer
4 for the Montana Attorney General's
5 Office.

6 MS. DEYNEKA: And Natalie Deyneka,
7 also with MotleyRice and Linda Singer.

8 MS. SINGER: And on the phone,
9 Kelly Hubbard from the Montana Attorney
10 General's Office.

11 MS. ANDERSON: I'm Kaitlyn
12 Anderson, in-house counsel for Cardinal
13 Health.

14 MS. WICHT: Jennifer Wicht from
15 Williams & Connolly for Cardinal Health.

16 MR. TULLY: Josh Tully from
17 Williams & Connolly, also for Cardinal
18 Health.

19 THE WITNESS: Todd Cameron of
20 Cardinal Health, the anti-diversion
21 group.

22 - - -

23 TODD CAMERON

24 being by me first duly sworn, as hereinafter certified,

1 testifies and says as follows:

2 EXAMINATION

3 BY MS. SINGER:

4 Q. All right. So as we're getting
5 started, I just want to give you some
6 suggestions, ground rules, whatever you want to
7 call them. Take as much time as you need to
8 answer questions; standing, sitting, however you
9 want to do them.

10 If you don't understand a
11 question, please ask me to rephrase it or ask me
12 to explain what I mean. You were sworn in at
13 the start of this testimony. I take it you
14 understand that you are testifying under oath
15 subject to a subpoena for testimony by the
16 Montana Attorney General's Office?

17 A. Yes.

18 Q. And you understand that a court
19 reporter is going to be transcribing your
20 testimony.

21 A. Yes.

22 Q. Is there any reason you can't
23 testify truthfully today?

24 A. No.

1 Q. Have you ever testified in
2 connection with Cardinal's anti-diversion
3 program?

4 A. No.

5 Q. And how much time did you spend
6 preparing for this deposition -- this testimony?
7 We'll call it testimony. That's what it is
8 under Montana law. How much time?

9 A. This deposition specifically?

10 Q. Yes.

11 A. Several hours.

12 Q. Okay. And other than your counsel
13 at Cardinal and at Williams & Connolly, is there
14 anyone else you consulted with in preparation
15 for today's testimony?

16 A. Counsel at BakerHostetler.

17 Q. Okay. Any non-lawyers?

18 A. No.

19 Q. And were there any documents that
20 you reviewed?

21 A. Yes.

22 Q. And what documents did you review?

23 MS. WICHT: Linda, I'll -- I think
24 that we've generally been doing this. I

1 object on the basis of privilege to just
2 the question asking him to identify all
3 documents. So I will instruct him not
4 to answer that one.

5 To the extent there are individual
6 documents that you show him and you want
7 to ask if he reviewed that in prep, I
8 would allow him to answer that.

9 MS. SINGER: Okay.

10 BY MS. SINGER:

11 Q. Are there any documents that you
12 reviewed on your own initiative that weren't
13 shown to you by counsel?

14 A. No.

15 Q. Okay. And did you review the
16 subpoena that was issued by the Attorney
17 General's Office in advance of coming today?

18 A. No.

19 Q. Okay. Do you know the topics or
20 subjects that were identified on that subpoena?

21 A. No.

22 MS. SINGER: So this is going to
23 be Exhibit 1.

24 - - -

1 (Montana-Cardinal Exhibit 1 marked.)

2 - - -

3 A. Should I read this?

4 Q. Yes. If you could take a look --
5 focus on the list of topics or subject areas.
6 That's at page III. It's III, "Subject Matters
7 for Testimony." If you could just skim through
8 those, please.

9 MS. WICHT: You can go ahead and
10 read that. While he's reading that,
11 Linda, my understanding of the
12 discussions that we had leading up to
13 this deposition are that -- and what
14 we're prepared to do today -- is that
15 Mr. Cameron is here in his individual
16 capacity, not as sort of a corporate
17 representative of Cardinal Health.

18 So I think -- and we'll see once
19 he reviews -- but I think he's -- in his
20 personal knowledge would cover many of
21 these. But we didn't prepare him as a
22 corporate witness. And he's not being
23 offered in that capacity today.

24 MS. SINGER: Yes. That is

1 understood.

2 MS. WICHT: Okay.

3 BY MS. SINGER:

4 Q. Mr. Cameron, have you had a chance
5 to look at the list of subjects?

6 A. Yes.

7 Q. All right. Are you familiar with
8 all of those subject areas in your work at
9 Cardinal?

10 A. I am familiar with the areas, yes.

11 Q. Okay. When did you start working
12 at Cardinal?

13 A. August of 1993.

14 Q. Was it your first job?

15 A. It was.

16 Q. And in what capacity did you start
17 with the company?

18 A. I was involved in the IT
19 department around data elements of the
20 distribution side of the company.

21 Q. And was that on the compliance or
22 marketing side of Cardinal Health?

23 A. Marketing.

24 Q. And can you take us through your

1 positions at Cardinal Health.

2 A. I can try. I was in --

3 Q. If you can't, I can't.

4 A. Right. Yeah.

5 I was in the -- and the reason I
6 hesitate is when I started, the company was very
7 small. And we didn't have the specific
8 department structure silos that we have today.
9 It was really kind of a group of -- it was very
10 small. It was about 70 people when I started.

11 But I was in the marketing
12 department as far as customer data elements that
13 were used on the distribution side of the
14 business, and moved into an IT role that was
15 focused around customer IT solutions from an
16 inventory management standpoint side.

17 And then moved into what at the
18 time was referred to as sales administration.
19 Then went back into another IT role. Then went
20 into a consumer health role, which was all the
21 front-end nonprescription products that Cardinal
22 carries.

23 Then went back into a sales
24 operations role. And then went from there into

1 the anti-diversion team. And each of those
2 steps had two or three jobs within those
3 movements.

4 Q. Okay. And so what is your current
5 title at Cardinal?

6 A. I believe it is -- and I say that
7 because I'm not sure what the actual HR roadmap
8 title is. But I believe it is SVP of supply
9 chain integrity.

10 Q. All right. Do we need to check
11 your business card?

12 A. Yeah, I don't have one with me.
13 But I think that's what it says.

14 Q. So this is not the part of the
15 testimony where you're supposed to get squishy?

16 A. Well, I haven't stood up yet. So
17 I'm still sitting down.

18 Q. Okay. And so in your current
19 position, whatever it is, at Cardinal Health,
20 you're responsible for anti-diversion
21 compliance; is that correct?

22 A. Correct.

23 Q. And when did you first move into a
24 role related to anti-diversion compliance?

1 A. Late 2012.

2 Q. And what were the circumstances of
3 that transition?

4 A. I moved in I believe it was
5 September of '12. I was asked to take a lateral
6 move into that role from my current position at
7 the time to help the company continue to evolve
8 its anti-diversion program focused on data and
9 analytics.

10 Q. And did you succeed somebody in
11 that position?

12 A. I did.

13 Q. And who was that?

14 A. Michael Mone.

15 Q. And to the extent you know, why
16 was he moved from that position?

17 A. I don't know. I know that Michael
18 is still here in a similar level capacity today
19 doing things with the Boards of Pharmacy.

20 Q. And do you know why you were
21 chosen for the position?

22 A. I was under the impression that
23 they wanted somebody that was good with numbers
24 and could understand customer data and help

1 determine what objective components would make
2 sense to evaluate customers.

3 Q. Okay. And is that the same
4 position that you're still in now?

5 A. Basically, yes.

6 Q. Okay. And how many people report
7 to you?

8 A. About 35.

9 Q. And what job functions do they
10 have? What kind of people are we talking about?

11 A. As far as the roles?

12 Q. Yes.

13 A. Everything related around to
14 anti-diversion, knowing our customers, setting
15 thresholds, doing visits.

16 MS. SINGER: And let me just pause
17 for a second.

18 Kelly Hubbard, can you hear us
19 okay?

20 MS. HUBBARD: Yes, I can. Thank
21 you.

22 BY MS. SINGER:

23 Q. Before you took this new position
24 or at any point, I take it you don't have any

1 background in law enforcement or compliance?

2 A. I do not.

3 Q. And what awareness did you have
4 of --

5 A. I have a criminal justice degree,
6 but that probably doesn't count.

7 Q. As long as you don't have other
8 criminal justice experience, that's a positive.

9 What was your awareness of opioid
10 diversion and abuse at the time you moved into
11 your current position?

12 A. At the time of the move, it was, I
13 would say, probably equal to other Cardinal
14 employees that were not part of the
15 anti-diversion group.

16 Q. So specifically what were your
17 impressions about issues around opioid diversion
18 at that time?

19 A. I knew that we obviously
20 distributed controlled substances. I knew that
21 we distributed C-IIs, that we had a vault that
22 those were kept in that had specific ordering
23 requirements from customers. We had certain
24 recordkeeping requirements.

1 And I knew that we supplied C-III
2 through Vs that were kept in a cage that had
3 different but still restrictions around them
4 from a customer ordering and recordkeeping
5 standpoint. And that was pretty much it.

6 Q. And when you talk about C-II and
7 C-III through C-V, those are the schedules of
8 controlled substances --

9 A. Yes.

10 Q. -- according to the DEA?

11 A. Correct. Yes.

12 Q. And did you have any awareness of
13 outside of Cardinal what was going on with
14 opioid abuse and diversion in the larger
15 society?

16 A. No. Not from a prescription
17 standpoint. Obviously I knew of heroin and
18 cocaine and drugs like that.

19 Q. And what marching orders were you
20 given when you came into the position?

21 A. I was instructed to continue to
22 evolve and build out the objective data driven
23 system and to help educate the business and the
24 sales forces on the components of the program

1 and to be able to help evaluate customers.

2 Q. And was there a specific
3 deficiency or gap that you were brought in to
4 help fill?

5 A. Not that I was aware of, no.

6 Q. And in your position, both from
7 the get-go until now, who are the people you
8 work with most closely?

9 A. I mean, I work obviously with my
10 team very closely. Every day I work with the
11 business side of the company, those that are
12 interacting more directly with the customers. I
13 work a lot with the legal teams around all the
14 pieces that we're putting together and rolling
15 out.

16 Q. So who are the three to five
17 people that you interact most closely with?

18 A. Oh, gosh.

19 Q. We won't tell them.

20 A. Yeah. I don't know if I could
21 come up with only -- on a weekly basis, it's
22 probably 50 people that I interact with.

23 Q. Okay. And do you have a deputy, a
24 number two?

1 A. I have a next level down of direct
2 reports, but I've got more than one.

3 Q. How many?

4 A. Four.

5 Q. Okay. And who are they?

6 A. Kimberly Soisson, Patrick Dudley,
7 Rich Ryu, R-y-u, and Danielle Roberts.

8 Q. And who is your counterpart on the
9 sales side of Cardinal?

10 A. I don't believe that I have one.

11 Q. Okay. So since you started in
12 your SVP role in compliance, what has been your
13 role in developing and implementing Cardinal's
14 suspicious order monitoring program?

15 A. Can I go back one question?

16 Q. Yes.

17 A. So from a counterpoint standpoint
18 when I said I didn't have one, there are SVPs on
19 the sales side, but they're broken up by
20 specific classes of customer trade.

21 Q. Okay.

22 A. So I don't have a one to one, but
23 there are four or five other SVPs that handle
24 the business side of things that I interact

1 with.

2 Q. Okay. Thank you for clarifying
3 that.

4 A. And I apologize. Can you ask the
5 question again?

6 Q. Yes. So since you took your
7 position as SVP on the compliance side in 2012,
8 what has been your role in developing and
9 implementing Cardinal's suspicious order
10 monitoring program?

11 A. I came in in September of '12, and
12 the foundational work of a lot of the components
13 that were going to be used to evaluate customers
14 had already been identified. And I've been
15 involved in constantly enhancing the use of
16 those. As obviously numbers continue to change,
17 areas of diversion change. So I've been
18 involved in continuing to evolve the core
19 components of the program that were in place
20 when I got there to where we are today.

21 Q. And that program, when did the
22 building out of that start?

23 A. I don't know. It was in place --
24 it had been going on when I arrived in September

1 of '12.

2 Q. Okay. And when you got started in
3 your position, what kind of work did you do to
4 familiarize yourself with the elements of the
5 program?

6 A. I spent a lot of time with the
7 leadership of the groups that touched the area
8 that I was involved in and then all the
9 individuals that had been doing a lot of work
10 prior to my arrival.

11 Q. And is that the same group that's
12 in those roles today, or was it a different
13 circle of people?

14 A. It was a slightly different circle
15 of people.

16 Q. So who else was in that mix?

17 A. Bob Giacalone, Gilberto Quintero,
18 Linden Barber, Nick Rausch.

19 Those are the names.

20 Q. And are those individuals still in
21 compliance functions at Cardinal?

22 A. One has left compliance and moved
23 into the business side, and one has retired.

24 Q. Which ones?

1 A. Bob has retired, Bob Giacalone has
2 retired, and Nick Rausch has moved into the
3 business.

4 Q. And the other two are still in
5 compliance at Cardinal Health?

6 A. Yes. Now -- I'm sorry. When I
7 say that, Linden was actually outside counsel at
8 the time and did not become in-house until about
9 a year ago. But I worked with him extensively.

10 Q. And over the period you've been in
11 this current role, have you ever received any
12 feedback from Cardinal that things weren't
13 moving quick enough, that you weren't doing
14 enough, any concerns expressed to you either
15 about the program or your performance?

16 A. No.

17 Q. Any concerns about the design of
18 the compliance program, the pieces of it, as you
19 talked about it?

20 A. No.

21 Q. Okay. And what about the
22 implementation of the compliance program, any
23 concerns expressed about that?

24 A. No concerns on any of the three

1 you just asked. Just obviously constant
2 discussion, awareness, making sure that all the
3 bases were covered.

4 Q. Okay. Who do you report up to in
5 having those conversations?

6 A. I report to Craig Morford.

7 Q. Whose position is?

8 A. I believe he is chief legal and
9 compliance officer.

10 Q. Have you made any recommendations
11 to Cardinal about its compliance efforts that
12 haven't been adopted?

13 A. No.

14 Q. Any places that, as you sit here
15 now, you think Cardinal could be working more
16 effectively to prevent diversion?

17 A. No.

18 Q. Any improvements that are on your
19 wish list of things to get done in the year or
20 years ahead?

21 A. Again, we are constantly evolving
22 and improving the system. And we literally on a
23 weekly basis will be evaluating threshold
24 setting, threshold methodology, threshold

1 events, to determine if we are setting the dials
2 correctly. But I don't have a specific thing
3 that has to happen.

4 Q. Okay. So you are satisfied that
5 there aren't currently any shortcomings in
6 Cardinal's compliance efforts or anti-diversion
7 efforts that need to be addressed?

8 A. From Cardinal's distribution
9 position that we sit in in the supply chain, no.

10 Q. And when you qualify that
11 response, what are you excluding?

12 A. I mean it would be great if there
13 was something we could do to decrease the
14 overprescribing of opioids. That would
15 obviously help a ton.

16 Q. Okay. Do you participate in your
17 current role at Cardinal in any trade
18 associations related to distribution or
19 compliance?

20 A. Does HDA qualify as one?

21 Q. In my book, yes.

22 A. Then, yes, HDA.

23 Q. And HDA is?

24 A. I'm not sure -- they've changed

1 their name recently. I'm not sure what HDA
2 stands for.

3 Q. Okay. Does it sound like the
4 Healthcare Distribution Alliance?

5 A. I think so, yes. There used to be
6 an M in there maybe.

7 Q. Used to.

8 A. Yeah.

9 Q. They rebranded.

10 A. Yes.

11 Q. What is your role on Cardinal's
12 behalf in the HDA?

13 A. Representing Cardinal on the calls
14 that take place with HDA and other distributors
15 around DEA compliance, anti-diversion issues,
16 new regulations that could be coming out from
17 either the federal government or specific state
18 governments.

19 Q. Are there other people from
20 Cardinal who participate in those calls?

21 A. There are.

22 Q. Who else?

23 A. I don't know everybody. I know a
24 lot of the regulatory lawyers are involved in

1 those calls. Gary Cacciatore, Martha Russell,
2 to name two of the attorneys that I think were
3 usually on those calls.

4 Q. And how often do those calls
5 happen?

6 A. I don't know that there's a
7 specific cadence. I would say it probably feels
8 like maybe monthly.

9 Q. And do you have an official role
10 in HDA? Do you serve on a board or a committee?

11 A. No.

12 Q. And, to your knowledge, does
13 anybody from Cardinal serve on the HDA's board
14 or committee?

15 A. I don't know. If they would, I
16 wouldn't know it.

17 Q. Okay. Are there any other
18 industry associations or organizations with
19 which you are involved?

20 A. No.

21 Q. Any associations that
22 manufacturers of opioids also participate in?

23 A. That I'm involved?

24 Q. Yes.

1 A. No.

2 Q. From your involvement in HDA
3 calls, is that only distributors of prescription
4 and other healthcare products or manufacturers
5 as well?

6 A. I believe on the calls that I'm
7 on, I think it's only distributors. But I know
8 there are a lot of other HDA calls that
9 different groups are involved in that I'm not
10 on.

11 Q. Okay. And the calls you
12 participate in, is there a particular subject
13 area or group that they fall within?

14 A. Usually related around controlled
15 substances. And, again, a lot of it's been
16 around potential new regulations coming out from
17 specific state Boards of Pharmacy lately.

18 Q. Okay. And I take it there are
19 e-mails that flow from HDA to you and other
20 members of that group about those topics?

21 A. I'm sure there are.

22 Q. Okay. Do you recall specifically?

23 A. I do not.

24 Q. And you mentioned that those calls

1 have been about regulatory developments.

2 A. Yes.

3 Q. Have there been discussions in
4 particular about DEA guidance and authority and
5 enforcement?

6 A. The two subjects that I think have
7 been the most common lately that I can
8 specifically recall are Ohio is putting out a
9 new regulation around controlled substance
10 distributions, the things that distributors are
11 required to do from a due diligence standpoint.
12 And New York has put out or is putting out an
13 opioid tax. Those have been -- probably the
14 last 15 calls I've been on have been about one
15 of those two subjects.

16 Q. Okay. And over the course of your
17 tenure, going back farther than the last couple
18 of weeks or months, are there other topics you
19 recall discussing?

20 A. No.

21 Q. Have there been any issues that
22 have come up relating to the State of Montana?

23 A. No, not that I can recall.

24 Q. Have you all discussed any issues

1 relating to Congressional oversight or inquiries
2 related to the distribution of opioids?

3 A. Not any calls I've been on.

4 Q. Any discussion of litigation over
5 the distribution of opioids?

6 A. Not on any calls I've been on.

7 Q. Or state enforcement activity?

8 A. Other than the potential reg
9 changes, no.

10 Q. And have you personally
11 participated in any meetings with the DEA about
12 Cardinal's compliance?

13 A. Yes.

14 Q. And how often and when? Can you
15 give us some details on that?

16 A. I've been to DEA headquarters
17 three times since I've been in the role.

18 Q. So this is going to be a piece of
19 cake compared to that.

20 A. Yes. They wouldn't let me stand
21 up either.

22 I think I was there twice in 2015,
23 or maybe once in '15 and once in '16. I can't
24 remember the exact time frame. And then I was

1 there again in the last six months.

2 Q. And what were the specific issues
3 that were discussed during those meetings with
4 the DEA?

5 A. We wanted to show our
6 anti-diversion program to DEA, make them aware
7 of kind of how we were doing the things that we
8 were doing, and talk to them about understanding
9 the suspicious orders that would be coming from
10 us. And then have conversations about trying to
11 have collaborative discussions to help both of
12 us in controlling diversion.

13 Q. And who did you meet with at DEA?

14 A. So the first two times Lou Milione
15 was the acting deputy administrator, I believe
16 was the title, and then probably ten people on
17 his staff. I can't remember all the specifics.
18 I remember Lee Reeves was in one of those
19 meetings.

20 And then this last time was with
21 probably about eight individuals from DEA. I'm
22 not sure exactly what level everyone was. But
23 Tom Prevoznik was the one -- was kind of, I
24 think, the ranking member of the room.

1 Q. Okay. And so when you say you
2 talked generally about your program and
3 suspicious orders DEA would be seeing, what
4 issues were you specifically lifting up for DEA?

5 A. I wanted DEA to understand the
6 filters that we used to evaluate customers, and
7 to get some of their feedback on those filters.
8 And then, again, to explain how we were using
9 thresholds to control the controlled substance
10 distributions that we were making to customers
11 that would lead to suspicious orders.

12 Q. When you say "filters," what do
13 you mean by that?

14 A. All of the objective criteria that
15 we use to evaluate a customer's business model,
16 the contextual size of the pharmacy, the
17 controlled substance ratios, potential mixes
18 within specific controlled substances from a
19 strength standpoint. Those types of things.

20 Q. And was there any specific event
21 or initiative that sparked any or all of those
22 meetings?

23 A. No.

24 Q. And other than those three

1 meetings, had you previously had any meetings
2 with the DEA?

3 A. No.

4 Q. And did you give any kind of
5 materials or presentation to DEA?

6 A. We presented each time to DEA, but
7 didn't leave anything.

8 Q. Okay. PowerPoint, I assume?

9 A. Yes.

10 Q. Okay. And who else was with you
11 from Cardinal?

12 A. The first time I went was Craig
13 Morford and Bob Giacalone. The second time I
14 went was Bob Giacalone and Al Santos who had
15 just retired from DEA. And then this last time
16 I went, it was just me and Linden Barber.

17 Q. And during each of those meetings,
18 did you get any feedback from DEA about what you
19 all were doing?

20 A. We did.

21 Q. And what was that feedback?

22 A. A lot of acknowledgment of
23 understanding now kind of how we set thresholds
24 and the effects that that then has on the number

1 of suspicious orders that we report to DEA. And
2 obviously DEA is not going to give you the Good
3 Housekeeping seal of approval, but they told us
4 that we were looking at all the right components
5 and looking at them in the right manner to run
6 an anti-diversion program.

7 Q. And when you talk about the
8 thresholds you were using to generate suspicious
9 orders --

10 A. Yes.

11 Q. -- again, what you were you trying
12 to clue DEA into?

13 A. So we -- one of the core
14 principles of our program is that we are going
15 to use thresholds to ensure that the controlled
16 substance distributions we make to customers
17 make sense. And that can be very tricky when
18 you have pharmacies that buy from three, four,
19 or five different wholesalers.

20 So we are focused on the slice, if
21 you will, of a business that comes to us from a
22 pharmacy, that we're going to ensure that that
23 specific slice looks within a normal range.

24 So you could have a pharmacy

1 that's very large and all in. They look normal.
2 And their ratios make sense. The volumes make
3 sense for the contextual size of the pharmacy.
4 But for whatever reason, they only want to give
5 you 20 percent of their total control and
6 non-control volume. We're going to make sure
7 that that 20 percent slice looks normal. Even
8 though in the total contextual size of the
9 customer, they could be fine, but you could be
10 getting a disproportionate share of controls
11 from one wholesaler. We are going to force that
12 volume to look normal based on how we set
13 thresholds, which can lead to a lot more
14 threshold events.

15 We wanted DEA to kind of get some
16 visuals of how we do that so they would
17 understand why we were reporting the number of
18 suspicious orders and the levels of pill volume
19 that was triggering suspicious orders for
20 potential customers.

21 Q. And were there any specific types
22 of customers or regions on drugs on which you
23 were focused with DEA, or was this an overall
24 presentation?

1 A. The focus from a drug standpoint
2 was oxycodone and hydrocodone. And we talked
3 about other drugs as well. But obviously those
4 are two of the main drugs that are abused today.
5 So we spent a lot of time on those drugs. But
6 there was no specific regionality to it. We
7 were looking at the entire country as a whole.

8 Q. And you said a couple of minutes
9 ago that DEA doesn't give a Good Housekeeping
10 seal of approval.

11 A. Yes.

12 Q. Is it true that DEA also
13 specifically says, "It's your job to design and
14 operate an effective program"?

15 A. That's what the reg says, yes.

16 Q. Okay. And that's what DEA, I
17 assume, also reiterates to you in these
18 meetings?

19 A. Yeah. Yes.

20 Q. Have you ever done any meetings
21 with members of Congress on Cardinal's behalf?

22 A. No.

23 Q. Any other regulators?

24 A. I've met with the Ohio Board of

1 Pharmacy. I'm trying to think -- I've met with
2 several DEA field offices. I think that's it.

3 Q. Okay. Do you know if you've ever
4 met with the DEA field office that covers the
5 State of Montana?

6 A. I don't know what office that
7 would be. I know I met with the DEA office that
8 is in Houston.

9 Q. What about Denver?

10 A. I didn't go to Denver. Houston.
11 And then I met with the office that is in
12 Louisiana. I think the office is actually
13 Mississippi, but they cover Louisiana. Those
14 are the two that come to mind.

15 Q. Okay. And in terms of the overall
16 focus of Cardinal's compliance efforts, you
17 mentioned that the DEA meetings focused on
18 oxycodone and hydrocodone. Is it those two
19 drugs that you and Cardinal have been focused on
20 or drug families?

21 A. No. There are over 100 DEA base
22 codes or drug families that we monitor. We've
23 got thresholds for every single one of those for
24 every customer that we have.

1 Q. In terms of the bulk of your
2 efforts, though, what drugs are you really
3 spending time worrying about and addressing?

4 A. We're focused on literally all 100
5 of the drug families from a methodology
6 standpoint. But the majority of our threshold
7 events are for either oxycodone or hydrocodone.

8 Q. Okay. And when you're talking
9 with your team as you've mentioned about
10 compliance, how much of your attention is on
11 opioids as opposed to other problem areas?

12 A. The majority.

13 Q. All right. So now in applying
14 your thresholds and evaluating and identifying
15 suspicious orders --

16 A. Yes.

17 Q. -- Cardinal relies on the order
18 data you have for your customers; is that
19 correct?

20 A. That is one component of it, yes.

21 Q. Okay. What are the other data
22 sources that you look at?

23 A. We have incorporated data from the
24 DEA that has been published. We've incorporated

1 data from the CDC, data from IMS, and data from
2 Symphony Health.

3 Q. What was the last one?

4 A. Symphony Health.

5 Q. Okay.

6 A. It used to be called Wolters
7 Kluwer, if that rings any bells.

8 Q. And I'm going to regret asking you
9 this question, but let's break those down.

10 So the data you get from ARCOS I
11 assume is the public reports that they do?

12 A. So the DEA publishes things
13 like -- and I'll butcher the name. But
14 dangerous drugs and something report that is
15 probably created from the ARCOS data. But it's
16 more aggregate level data across regions around
17 total opioid volumes and the -- I can't think
18 the word. For the manufacturers to -- the quota
19 data.

20 Q. And so when you talk about
21 Cardinal's 20 percent, for instance, with a
22 customer, the DEA's data gives you the whole
23 picture of all distributors?

24 A. Not at a customer level. Just

1 across broad geographies, yes.

2 Q. All right. So that's the DEA
3 data.

4 A. Yes.

5 Q. And then I think the next thing
6 you mentioned was CDC. What dataset is that?

7 A. So there's a lot of CDC reports
8 that we've used that look at prescribing, the
9 rate of prescribing, for example, for opioids;
10 is that going up? Is that going down? Average
11 pills per prescription. Those types of things.

12 Q. And when you look at the CDC data,
13 are you looking at data on overdoses and
14 hospitalization or any of the other kind of
15 wonder data?

16 A. We're focused on understanding
17 what the prescribing volumes are of those opioid
18 prescriptions. And, again, kind of pills per
19 script.

20 Q. Okay. So does that mean you're
21 not looking at hospitalization and overdose
22 data?

23 A. When you look at a lot of those
24 things, it includes opiates. So it's got

1 heroin. It's got the illicit street fentanyl
2 drug, which obviously we don't distribute.

3 So it has a lot of those things
4 factored in. And you can't tell necessarily how
5 much were driven from which. So there's not a
6 lot of value to us in that.

7 But, again, we're setting
8 thresholds at the customer level. So there's no
9 way to determine which customer from what
10 pharmacy might have gone to a specific hospital
11 obviously.

12 Q. Okay. So your -- just because I
13 want to get us to an answer on this --

14 A. Yes.

15 Q. -- understanding the reasons --

16 A. Yes.

17 Q. -- Cardinal is not looking at
18 overdose or hospitalization data to help you
19 focus on particular regions of the country or
20 drug sources, for instance?

21 A. No. We're focused on aggregate
22 level dispense data from other sources that we
23 could tie back to actual prescription
24 medications that are filled at pharmacies.

1 Q. And are you saying, Mr. Cameron,
2 that that data on hospitalizations and overdoses
3 doesn't serve a useful role for your compliance
4 program?

5 A. Yeah. I'm not sure how we would
6 be able to take hospitalization data that,
7 again, would include things like heroin and
8 figure out how to tie that back to a specific
9 pharmacy's level of prescriptions that they
10 filled. So I'm not sure how we would use that.

11 Q. Okay. So you wouldn't use it, for
12 instance, to see that there has been a spike of
13 overdoses in a particular state and know that
14 you want to look more closely at those
15 customers, for instance?

16 A. We look at all 40,000 customers
17 that we distribute to regardless of what
18 overdose rates look like.

19 Q. Okay. So that was CDC data.
20 I think the next you mentioned was
21 IMS data.

22 A. Yes.

23 Q. And what data do you get from IMS?

24 A. Again, there are a lot of

1 published IMS sources that look at prescribing
2 rates, pills per prescription, the morphine
3 milligram equivalences, grams across those
4 medications. So IMS gives us very good high
5 level industry data of what the trends are from
6 a prescribing standpoint.

7 Q. Okay. So what the volume of
8 prescriptions are --

9 A. Yes.

10 Q. -- what the nature of
11 prescriptions are?

12 A. Exactly.

13 Q. Okay. And that's proprietary data
14 that Cardinal purchases, correct?

15 A. No. It's -- well, I don't know
16 the answer. I know it comes from IMS. I'm not
17 sure -- there are a lot of groups within
18 Cardinal that work directly with IMS. It's not
19 just anti-diversion stuff. So I'm not sure if
20 it was stuff that was purchased or if it was
21 stuff that was published publicly by IMS or not.

22 Q. Okay. And are there particular
23 datasets from IMS that you use most heavily?

24 A. No. I mean, I think they're very

1 good on the prescribing trends and what the
2 morphine milligram equivalences are. Those are
3 probably the two main things.

4 Q. Okay. And do you use morphine
5 milligram equivalence or MMEs in setting
6 thresholds?

7 A. We use it to evaluate customers.
8 And then part of that evaluation will be to set
9 the threshold.

10 Q. So tell me what I said wrong that
11 you are correcting.

12 A. So we set thresholds off of the
13 contextual size of the pharmacy, how big is the
14 pharmacy from a total scripts control versus
15 non-control, and then what are the pills that
16 the pharmacy is requesting and potentially
17 dispensing.

18 Q. And the pills are the dosage
19 count?

20 A. I'm sorry. Yes. Dosage units,
21 yes.

22 Q. Okay.

23 A. The MME helps us level set the
24 strength of opioids, for example, across the

1 opioids. So it allows us -- because you could
2 have a pharmacy whose pill count is much lower
3 than other pharmacies but their MME could be
4 higher. So you can't just focus on the pills
5 themselves. You've got to evaluate all of that
6 context around those ratios.

7 Q. And is that something that happens
8 within the data system that's setting and
9 applying thresholds, or is that something that
10 happens when a Cardinal investigator looks at a
11 particular customer that's been flagged?

12 A. It's any time that we are
13 reviewing a specific customer, we're reviewing
14 that MME data.

15 Q. Okay. So it's not built into the
16 threshold levels themselves?

17 A. No.

18 Q. Okay.

19 A. And it would be very -- back to my
20 DEA meeting. Walking them through the program,
21 we report ARCOS data and suspicious orders at
22 the dosage unit level.

23 And, again, when you are focused
24 on ensuring that the volumes we distribute make

1 sense for the contextual size and share of that
2 size that comes through to Cardinal for that
3 specific pharmacy, if we kind of went the route
4 you were describing, we now would be reporting
5 suspicious orders to DEA on much lower pill
6 levels which would probably not make a whole lot
7 of sense and causing more confusion.

8 So it's very valuable for us to
9 evaluate the customers themselves, but we don't
10 use that specifically to set the threshold.

11 Q. Okay.

12 A. If that makes any sense.

13 Q. Okay. I think the next data
14 source you mentioned was Symphony or --

15 A. Yes, Symphony Health.

16 Q. Okay. And what data do you get
17 there?

18 A. Symphony, very similar company to
19 IMS as far as the output data-wise. And
20 Symphony we get blinded industry data for
21 pharmacies of overall size of the pharmacy,
22 oxycodone, hydrocodone volumes, opioid volumes.
23 Those types of things.

24 Q. And so that's by pharmacy without

1 identifying the pharmacy?

2 A. Exactly. Yes.

3 Q. So what does that let you see?

4 A. It allows us to understand what
5 normal is across the country. It allows us to
6 understand what a normal deviation range is. It
7 allows us to segment customers based off of risk
8 and to say, "This area should have this many
9 customers to look normal," and that type of
10 thing.

11 Q. Explain that last point to me.

12 A. It allows us to understand what
13 the bell curve looks like and how many fall into
14 which part of the curve.

15 Q. Have I missed any data source that
16 you're using in your anti-diversion efforts?

17 A. You mentioned the -- our own
18 Cardinal internal customer distribution data.

19 Q. Okay. So now Cardinal has -- when
20 we talk about Cardinal's order data, you have
21 data on your customers, controlled substances
22 and non-controlled substances.

23 A. Purchase-wise. Can I add one
24 thing back to your previous question?

1 Q. You can.

2 A. We also do have --

3 Q. That's actually the joy of being
4 in your position. You can always --

5 A. Well, I feel bad for her.

6 We also do have certain customers
7 that sign what we call a data feed. It allows
8 us to see at the pharmacy level their
9 adjudicated dispensing data.

10 Q. Their adjudicated? What does that
11 mean?

12 A. It means it's the data that runs
13 through the switch for third-party
14 reimbursement. So it does not include cash. So
15 it's not a complete picture. In some cases, it
16 could be 100 percent. In some cases, it could
17 be 50 percent. So it really varies by customer.

18 Q. Okay.

19 A. We also have that.

20 Q. Okay. And how many of your
21 customers, what proportion of your customers,
22 provide that data feed?

23 A. I don't know the exact number.
24 Speaking of like in the retail space, it's

1 probably half of the customers. But I will tell
2 you it's probably 80-plus percent of the volume.

3 Q. And that's true for controlled
4 substances in particular?

5 A. Both equally.

6 Q. Okay. And when we talk about
7 these data sources, by the way, these are the
8 same data sources that you've had available to
9 you for your tenure in this position?

10 A. We started purchasing the Symphony
11 data in 2013.

12 Q. Okay.

13 A. But everything else, yes.

14 Q. Okay. Now, I have to remember.
15 Yes.

16 So Cardinal's order data includes
17 controlled and non-controlled substances that
18 you sell to your customers, correct?

19 A. Yes.

20 Q. And that's different than what you
21 report to the DEA in ARCOS, which is only
22 controlled substances?

23 A. Yes.

24 Q. Okay.

1 A. And I say yes to that. I think
2 ARCOS is C-IIIs. And then the narcotic
3 analgesics that are III through Vs, I don't
4 think -- it's not all controlled substances that
5 are part of ARCOS.

6 Q. But you don't report to DEA any
7 non-controlled substances?

8 A. Correct.

9 Q. Okay. And so Cardinal can look at
10 how many controlled substances a customer or
11 customers in general are buying relative to
12 their non-controlled purchases?

13 A. Yes.

14 Q. And I think you mentioned earlier
15 that there's a ratio to that.

16 A. Yes.

17 Q. What is that ratio that triggers
18 an alert for Cardinal?

19 A. I hesitate on the word "alert."
20 Sorry. Again, we're reviewing every customer
21 that we distribute to. If you're asking me kind
22 of like what's normal. You know, that
23 20 percent line is about what I would say is a
24 normal ratio, 20 percent of controls to total.

1 Q. Okay. So you would -- to make
2 sure that I understand it and the record is
3 clear --

4 A. Yes.

5 Q. -- Cardinal would expect that your
6 customers are buying no more than 20 percent of
7 their orders are for controlled substances?

8 A. No. 20 percent, I would tell you,
9 is probably the average line across the country.

10 Q. Okay.

11 A. For not just Cardinal. For the
12 industry as a whole.

13 Q. Okay. And so how do you integrate
14 that 20 percent ratio into your compliance
15 efforts?

16 A. As we're reviewing customers, that
17 is one of the factors we look at, to see what
18 that control percentage is.

19 Q. Okay. And is that applied within
20 these datasets to identify customers who you
21 ought to be looking at?

22 A. Yes.

23 Q. Okay. And I'm responding to a
24 hesitance in your face as you answer that.

1 So is there some scan that
2 Cardinal is doing of its order data to identify
3 customers who purchase -- whose orders include
4 more than 20 percent controlled substances?

5 A. And I hesitated on the term
6 "orders."

7 Q. Okay.

8 A. So obviously a lot of orders
9 themselves will just be controlled substances.
10 So 100 percent of that order would be controls,
11 especially because CSOS and the 222 forms that
12 customers use to order C-IIs, nothing goes on
13 there but C-IIs. So that order would be
14 100 percent for controls always.

15 Q. So when you're looking at a
16 customer's data to apply that ratio --

17 A. Yes.

18 Q. -- are you looking at monthly
19 data, annual data?

20 A. Monthly.

21 Q. Okay. And is that a fixed monthly
22 period, or is it a rolling 30-day period?

23 A. The review would be a fixed month.
24 And I hesitated because we have monthly

1 thresholds, but they're staggered during the
2 month. So some are set on the 8th, some on the
3 15th, some on the 22nd. So everybody's
4 threshold doesn't reset on the same day, but the
5 review takes place during that calendar month.

6 Q. Okay. And are the different
7 threshold periods staggered by customer segment?

8 A. They're staggered by customer
9 segment and by distribution center.

10 Q. Okay.

11 A. It allows us to put greater focus
12 on reviewing that customer when the held order
13 takes place. Because they don't all happening
14 at the end of month at the same time, for
15 example.

16 Q. Okay. Based on Cardinal's order
17 data, we've talked about the fact that you can
18 look at controlled and non-controlled substances
19 across a customer's orders and across your
20 customers. I take it you can also look at how
21 controlled substances are purchased together?

22 A. Yes.

23 Q. And is Cardinal looking, for
24 instance -- are you able to look at whether a

1 customer is buying certain combinations of
2 controlled substances or non-controlled
3 substances that may signal diversion?

4 A. Yes.

5 Q. And what are those combinations
6 you're looking for?

7 A. We're looking at opioids overall,
8 so not just oxycodone and hydrocodone, all the
9 opioids combined. We're looking at the percent
10 that's benzos. We're looking at the percent
11 that's ADD/ADHD drugs. Again, we're looking at
12 total controls. We're breaking out oxycodone
13 and hydrocodone. We're breaking out oxycodone
14 and hydrocodone within each family from a
15 strength standpoint. Those type of things.

16 Q. Okay. And so when you say you're
17 looking at that, first of all, I just want to
18 establish, so you have all of those different
19 data fields?

20 A. Yes.

21 Q. And then when you're looking at
22 what you described there, which is combinations
23 of drugs, non-opioids, strengths of opioids, are
24 you looking at that for a threshold purpose or

1 for customer evaluation or both?

2 A. Both.

3 Q. Okay. Explain how they're
4 integrated in setting thresholds in the first
5 place.

6 A. So all of those factors, we are
7 using that data to determine should we even
8 distribute to that customer at all. And then
9 we're using it to determine what the threshold
10 should be if we are going to distribute.

11 Q. Okay. And are those -- are those
12 thresholds set on a customer-by-customer basis?

13 A. Yes.

14 Q. So a customer in Helena, Montana
15 may have a different threshold for hydrocodone
16 than a customer in Whitefish?

17 A. Yes.

18 Q. And that's true even if they're in
19 the same customer segment, meaning they're both
20 small independent pharmacies?

21 A. Yes.

22 Q. And will they also have a
23 threshold for benzodiazepines?

24 A. Yes, absolutely.

1 Q. Okay. And those may be different
2 as well?

3 A. Yes.

4 Q. And how many of your customers
5 have individualized thresholds versus
6 class-specific thresholds?

7 A. We maintain over 10 million
8 thresholds on a daily basis. So I'm not --
9 there would be a lot of overlap that your two
10 stores might have the same threshold, but they
11 don't have the same threshold on purpose to make
12 them the same.

13 It's the context for your
14 individual store versus her store would dictate
15 what that threshold looked like. But they could
16 end up being the same. But they're not
17 necessarily the same on purpose.

18 Q. Are there customers for which you
19 can't set an individualized threshold?

20 A. No.

21 Q. Okay. And the threshold is driven
22 by the order data --

23 A. Yes.

24 Q. -- for that customer, the order

1 data for other customers --

2 A. Yes.

3 Q. -- and the other data sources that
4 you've described --

5 A. Yes.

6 Q. -- correct?

7 And are you looking at the
8 population in Helena versus the population in
9 Whitefish, too?

10 A. We're not looking at the
11 population. But we're looking at the total
12 contextual size for the pharmacy of the control
13 and non-control volume of that pharmacy, which
14 is an indicator of the foot traffic, control and
15 specifically non-control, that's going into that
16 pharmacy.

17 Q. And when you say "size," you mean
18 the size of the orders?

19 A. No. The size of the script volume
20 of control and non-control, or the pill volume
21 control and non-control.

22 Q. Okay. So explain that.

23 A. So we would expect a
24 1,000-script-a-day pharmacy to do a lot more

1 oxycodone than 100-script-a-day pharmacy does.

2 Q. In absolute numbers but not
3 relatively?

4 A. I'm not sure I follow you.

5 Q. So you would expect if that
6 1,000-script pharmacy is within the normal range
7 of having no more than 20 percent controls --

8 A. And I'm sorry to interrupt you.
9 But 20 percent is not the range. That's the
10 stone cold average. It's not the range.

11 Q. Okay.

12 A. Yeah.

13 Q. Okay. And that 20 percent is all
14 the controlleds, not just oxycodone?

15 A. Absolutely.

16 Q. You expect that pharmacy that's
17 writing a 1,000 -- dispensing 1,000 scripts to,
18 let's say, have 100 oxycodone prescriptions that
19 it's dispensing?

20 A. Yeah. For example, yes.

21 Q. Okay. And if --

22 A. That's not a real ratio, but that
23 would be an example number, yes.

24 Q. Okay. And so when you say you're

1 looking at the contextualized footprint, tell
2 me --

3 A. That that pharmacy that's filling
4 1,000 prescriptions a day has got a lot more
5 control and non-control volume to that pharmacy
6 than the one that's only filling 100 scripts a
7 day.

8 Q. Okay. And how does that get you
9 to population?

10 A. Well, because you've got people
11 who are coming in getting prescriptions filled
12 in that pharmacy.

13 Q. Okay. And is there a reason
14 Cardinal doesn't look at population data?

15 A. Again, we're using the
16 prescription volume as the indicator for the
17 contextual size ensuring that the ratios within
18 that volume looks within a normal range.

19 But I'm not sure how you would
20 then set population to a threshold not knowing
21 what people or population went to which
22 pharmacy, especially when pharmacies border
23 other states. And we have lots of pharmacies
24 that have customers that the closest pharmacy is

1 in the next state away that's only two miles
2 from them.

3 Q. Right. But you could use Zip
4 Codes and other factors to --

5 A. You could. But, again, you're
6 still going to have people traveling in and out
7 of, and you'd have to be able to debit from this
8 three-digit Zip. And you wouldn't know where
9 the patient came from.

10 Q. All right. But you do know how
11 many pharmacies are in an area?

12 A. You do. But, again, you don't
13 know what patient came from what other
14 three-digit Zip Code into that three-digit Zip
15 Code, which is why we use the scripts. And we
16 ensure that the volumes is within that -- meet a
17 normal standard.

18 Q. How many orders of opioids does
19 Cardinal process in a year?

20 A. I don't know the answer to that.
21 I'm not sure how many actual orders.

22 Q. What volume of opioids, then, do
23 you distribute in a year?

24 A. Off the top of my head, I couldn't

1 tell you what that number is.

2 Q. Has that number -- all of the --
3 we've covered a lot of this, so let me just
4 catch up.

5 Does any of the data sources that
6 Cardinal purchases allow you to get a sense of
7 your market share?

8 A. Yes.

9 Q. And what data is that?

10 A. The Symphony Health data does.
11 The IMS data might also.

12 Q. And do you use that market share
13 data in inferring the other supplies of opioids
14 into an area or to a customer?

15 A. In that data, you cannot see who
16 the customers are. It's blinded data. So
17 there's no way from that data to know what a
18 specific customer's other volume would be from
19 that data.

20 Q. But you do know in an overall
21 geographic area, for instance?

22 A. You do. Now, the data is not
23 100 percent of the pharmacies. So there are
24 pharmacies that are excluded. And it could be

1 peanut buttered across the country that it's an
2 equal chunk missing from every state, or you
3 could have 100 percent in one state and only 50
4 in the other, and you would get a false sense of
5 security from that data, and that comp is
6 missing.

7 Q. But that's true, I assume, of all
8 of the different data sources then. There are
9 going to be gaps and overrepresentations?

10 A. Yes.

11 Q. Okay. It's not distinct to the
12 Symphony data you're talking about?

13 A. No. Any industry data is not
14 going to be complete. It won't give you a
15 complete picture of all the customers or all the
16 volume.

17 Q. Okay. Does Cardinal get any
18 information on pharmacy robberies or
19 drug-related arrests or any indications of
20 diversion, trafficking, et cetera?

21 A. We're obviously monitoring the
22 media reports that come out every day when
23 pharmacies get raided or busted. And then if a
24 pharmacy is robbed, we require them to provide

1 us with a copy of the 106 form that they turn in
2 to DEA so we can verify that they were robbed.

3 Q. Okay. So how are you using the
4 media scans you're doing, for instance, in your
5 compliance program?

6 A. It allows us to know, one, if a
7 specific pharmacy has gotten in trouble.
8 Because the majority of the stories are usually
9 around bad patients that were selling
10 prescriptions, which we don't have any
11 visibility due to who the patient is at the
12 pharmacy level, so it helps us to know what
13 areas there's activity going on from a law
14 enforcement standpoint.

15 Q. Okay. So you use it to monitor
16 specific customers?

17 A. Specific areas, yeah.

18 Q. Okay. So I'm sorry. Explain how
19 the news reports get you to a specific area.

20 A. There would be a news report that
21 says a pharmacy in Smithville USA was shut down
22 by the DEA.

23 Q. Okay. And then where do you go
24 from that?

1 A. So we would take a look at
2 Smithville.

3 Q. You'll look across all of your
4 customers in Smithville?

5 A. Yes.

6 Q. What will you do with those
7 customers?

8 A. Depends. You know, looking at the
9 ratios and the numbers, determine if we need to
10 do extra site visits on those pharmacies,
11 determine if we need to escalate them through
12 our review process.

13 Q. And why would a particular
14 pharmacy in Smithville that has been the subject
15 of a DEA action signal that there are other
16 pharmacies in that area that may be problems
17 too?

18 A. Well, oftentimes if that pharmacy
19 got raided, they're not going to be able to fill
20 prescriptions anymore because they've been shut
21 down. So now that volume is going to go to the
22 other pharmacies in the area. So we want to be
23 ahead of that volume shifting to any of those
24 pharmacies that might be our customers so we can

1 understand what's going on.

2 Q. Meaning so that you won't have
3 thresholds cut off the supply they will need to
4 meet that customer --

5 A. Meaning --

6 Q. -- demand?

7 A. Meaning that's probably not good
8 demand.

9 Q. That's probably what?

10 A. Probably not good demand.

11 Q. Okay.

12 A. If that pharmacy was raided and
13 shut down, they probably weren't filling
14 prescriptions that they should have been
15 filling, and that's probably not a volume you
16 want going to your other customers.

17 Q. Okay. So if you see that, an
18 increase in orders for controlled substances in
19 other pharmacies, you're going to want to pay
20 attention to that?

21 A. Absolutely, yes.

22 Q. And do you get any aggregate law
23 enforcement data?

24 A. No.

1 Q. Okay. And Cardinal doesn't have
2 any hot spots or zones that you focus on
3 geographically?

4 A. We look at all 40,000 customers we
5 distribute to.

6 Q. Does Cardinal ever look at the
7 volume of opioids that goes into a jurisdiction
8 to determine whether there is likely diversion
9 in that area?

10 A. We are setting the thresholds for
11 all 100 drug families for every customer at the
12 customer level and evaluating each pharmacy
13 individually.

14 So if you evaluate the risk of
15 those pharmacies and set those thresholds
16 properly, some of the parts can't be greater
17 than the whole. So there would be no issue
18 there.

19 Q. Unless you're wrong? Yes or no?

20 A. I'm not sure what you mean by
21 "wrong."

22 Q. Well, it seems to me, as somebody
23 who's a lawyer and not a data person or an IT
24 person, that one check on whether the thresholds

1 have correctly calibrated the volume would be
2 whether they add up to the sum that doesn't make
3 sense --

4 A. Right.

5 Q. -- for the individual factors?

6 A. And if every pharmacy makes sense,
7 then what you described can't happen.

8 Q. Unless it happens?

9 A. Well, it can't happen. That's not
10 how thresholds work.

11 Q. So then how do you explain a town,
12 Smithville in USA or Whitefish in Montana, when
13 you have a volume far exceeding the customer
14 base?

15 A. You've got a distributor that was
16 potentially distributing too many controlled
17 substances into that area. But, again, when
18 you're using the script volume as the context --
19 so if every pharmacy in the area is at a normal
20 range, then the sum of all those pharmacies
21 would still be at a normal range.

22 Q. And so why wouldn't you, just as a
23 belt and suspenders step, also use a
24 population-to-supply metric just to make sure

1 that there wasn't something happening that was
2 problematic?

3 A. And we're doing that with our
4 script data.

5 Q. Explain how you're doing that.

6 A. We're looking at what the ratios
7 are to the total prescriptions, control and
8 non-control, for opioids.

9 Q. Okay. So you have one measure,
10 but you're not doing the "We're supplying, as
11 Cardinal and as a share of a market, this many
12 opioids into a place compared to the population
13 of that place"? You're not doing that?

14 A. No. No. We're looking at the
15 script volume of those pharmacies and then the
16 share of that volume that's coming from us and
17 then analyzing the opioid volume.

18 (Reporter clarification.)

19 A. We're using the script data to
20 ensure that the opioid volume is within a normal
21 range within the total volume of the pharmacy.

22 Q. Okay. Right. But you could also
23 say, "No. You're not using population. You're
24 doing something different."

1 A. Yeah.

2 Q. Okay. If Kelly Hubbard on the
3 phone was to tell you hypothetically that
4 Whitefish, Montana, population 7,000, was
5 getting 10 million dosage units of opioids every
6 year, would you think that there was a problem
7 with that distribution into Whitefish?

8 A. I would not be able to make that
9 assumption without seeing each individual
10 pharmacy and what each individual's pharmacy and
11 distributions and ratios look like within
12 Whitefish.

13 Q. And what if it was a billion
14 pills?

15 A. The opioid volume?

16 Q. Mm-hmm.

17 A. Again, I would need to know -- I
18 don't know how many pharmacies that are in
19 Whitefish. I don't know what cancer centers are
20 in Whitefish. I don't know anything about
21 Whitefish specifically. I would need to see
22 each pharmacy individually and evaluate each one
23 of them individually.

24 Q. And if we told you that there was

1 no cancer center or hospital in Whitefish --
2 let's take out some of the variables that I
3 understand you're putting into this with
4 reason -- would that change your view?

5 A. Again, I would need to see each
6 individual pharmacy to make that evaluation.

7 Q. So there's no volume of opioids
8 into a place that would be a categorical red
9 flag to you that there was diversion in that
10 area?

11 A. I don't want to make the general
12 statement yes or no without being able to see
13 each individual pharmacy and evaluate each one
14 of those.

15 Q. So the answer is no, there's no
16 level that would be a red flag --

17 A. Without seeing the pharmacies.

18 Q. -- without seeing --

19 A. Yes, yes.

20 Q. Okay. Are you familiar with
21 reports that the DEA puts out, Report 4 and
22 Report 5, each year on state and Zip Code data
23 on the supply of scheduled controlled substances
24 into a jurisdiction?

1 A. I am not.

2 Q. Okay. So obviously if you're not
3 familiar with those, you don't review them?

4 A. No. I never heard the term Report
5 4 or Report 5 before.

6 Q. Okay. Do you look at the increase
7 of opioids into a jurisdiction year over year in
8 looking at compliance efforts or potential
9 diversion?

10 A. From our distribution --

11 Q. Yes.

12 A. -- volume? Yes.

13 Q. Okay. And how do you do that?

14 A. We're looking at everything from
15 the customer level up.

16 Q. Okay. So let's go back to poor
17 Whitefish.

18 A. Yes.

19 Q. And I should be clear. I'm not
20 signaling out Whitefish for any particular
21 reason.

22 A. Yes.

23 Q. But you would look at Cardinal's
24 overall supply of opioids into Whitefish and

1 say, "Wow. That went up 10 percent this year"?

2 A. We would look at every pharmacy in
3 Whitefish and analyze each individual pharmacy.

4 Q. Okay. So you're not looking at
5 Whitefish as Whitefish but Whitefish as a series
6 of individual pharmacies, that you're looking at
7 increase of every pharmacy?

8 A. Yes.

9 Q. Okay. That was very inarticulate,
10 but I think we understand each other.

11 A. Yes.

12 Q. We talked about --

13 MS. WICHT: I only was taking a
14 breath to say we -- Todd, we've been
15 going for about an hour, and I just want
16 to check in. If you're doing okay --

17 THE WITNESS: I'm okay.

18 MS. WICHT: -- it's fine to keep
19 going. Okay.

20 BY MS. SINGER:

21 Q. We talked about the prescription
22 data that Cardinal gets from IMS and Symphony.

23 Cardinal has a joint venture
24 called ArcLight. Are you familiar with that?

1 A. I know ArcLight was a company
2 that -- I think ArcLight has been out of
3 business for like ten years.

4 Q. Okay. Okay. And so while -- and
5 that would have preceded your tenure?

6 A. Yes. I don't know that it's been
7 ten years, but I don't -- I think it's been
8 quite a while that ArcLight has been formed.

9 Q. So it's not in business now?

10 A. Not that I'm aware of, no.

11 Q. Okay. And there's no data that
12 comes from this entity in the period that it was
13 in operation that you all used for compliance
14 functions?

15 A. No.

16 Q. Okay. What about -- what are
17 Medicine Shoppe and Medicap Pharmacy. Are you
18 familiar with those?

19 A. I am.

20 Q. And what are they?

21 A. They are -- it is a franchise of
22 pharmacies that kind of operates as a co-op
23 across a common branding theme for the
24 pharmacies.

1 Q. So it's like a marketing
2 assistance program --

3 A. Yes.

4 Q. -- that Cardinal provides to
5 certain pharmacies?

6 A. Yeah. It's a franchise.

7 Q. Got it.

8 A. Yes.

9 Q. And Cardinal owns this?

10 A. I'm not sure what capacity. But,
11 yes, we've got some -- something to do with the
12 Medicine Shoppe franchise.

13 Q. Okay. And do you distribute
14 opioids to these pharmacies, too?

15 A. To some of them. They don't have
16 to buy from us.

17 Q. And do you get their dispensing
18 data?

19 A. If they are customers that are
20 part of that batch I talked about earlier that
21 have signed up, then yes.

22 Q. Okay. But that's not all of them?
23 It's not a condition of their franchise?

24 A. No. They're not required to buy

1 from us either.

2 Q. Okay. And Kenray, are you
3 familiar with that?

4 A. I am.

5 Q. And what is Kenray?

6 A. Kenray is a former regional
7 distributor in New York that Cardinal acquired
8 in the 2010, 2011, '12 time frame.

9 Q. Okay. And so that just became
10 part of Cardinal's operations?

11 A. Exactly.

12 Q. Did you acquire its data and order
13 history, too?

14 A. Yes.

15 Q. And do you use that for compliance
16 purposes?

17 A. We have owned them since I've been
18 in the role the entire time. So they all would
19 have been part of the normal Cardinal data when
20 I came on board.

21 Q. Now, the data that you get from
22 IMS on prescribing and from Symphony and the
23 data feed --

24 A. Yes.

1 Q. -- I think those are the three
2 sources that give you prescription data and
3 dispensing data; is that right?

4 A. Yeah. I wouldn't say IMS. IMS is
5 more aggregate level overall industry numbers.
6 But the other two get down to more granular.

7 Q. Okay. Are there any other data
8 sources that give you the more granular
9 prescribing and dispensing data?

10 A. No.

11 Q. Okay. And do you use that data --
12 forgive me if we've gone over this.

13 Do you use that data in your
14 granular compliance efforts? Is that
15 integrated?

16 A. Yes.

17 Q. Okay. And in what system does all
18 of this data live?

19 A. A lot of them -- we've got
20 multiple IT systems that talk to each other that
21 some data -- partial is housed here, and other
22 pieces housed here, and we've got to pull it
23 together into a different system to use it, that
24 type of thing.

1 Q. Okay. And what is the master
2 system?

3 A. There isn't one master system.
4 They're all different individual standalone
5 systems with multiple purposes, and some
6 purposes overlap and some don't.

7 Q. But from a compliance perspective,
8 you have access to all of that data
9 collectively?

10 A. Yes.

11 Q. And do you use that data in
12 setting thresholds?

13 A. Yes.

14 Q. Is there any data source that
15 tells Cardinal when a pharmacy dispenses drugs
16 to an out-of-state customer?

17 A. No.

18 Can I correct one thing I said
19 last on the question?

20 We use all that data to evaluate
21 the customers and to understand that contextual
22 size, and that's how we set the thresholds. So
23 it's basically what you said, but it's slightly
24 different.

1 Q. Okay. Tell me the difference.

2 A. That data does not set thresholds.

3 That data helps complete the picture of the
4 customer, and that picture determines the levels
5 we're comfortable distributing.

6 Q. Okay. We'll come back to that.

7 A. Okay.

8 Q. So do your pharmacy customers tell
9 you who their biggest prescribers are for
10 controlled substances?

11 A. Not necessarily.

12 Q. Do some of them?

13 A. If we ask.

14 Q. And when would you ask a pharmacy
15 that question?

16 A. It would depend on the specific
17 numbers and questions that we would have around
18 some of the numbers for the pharmacy that could
19 potentially lead to getting into prescriber
20 conversations.

21 Q. So would you ask that as part of
22 your Know Your Customer process for a new
23 customer?

24 A. It would depend on the numbers.

1 Q. And which numbers?

2 A. Depends on the drug. So if
3 numbers are outside of normal ranges and that we
4 don't understand why for that type of pharmacy
5 or that contextual size, we could ask those
6 questions.

7 Q. Okay. But it's not part of your
8 standard onboarding unless there are questions?

9 A. Yes.

10 Q. And when you do have questions and
11 you get that data, do you run that prescriber
12 data against the IMS data or the Symphony data
13 or any other data source you have?

14 A. I'm sorry. Which data?

15 Q. The biggest prescribers to a
16 pharmacy.

17 A. There is no prescriber data in any
18 of that data.

19 Q. Okay. Do you look those
20 prescribers up in the DEA license lookup?

21 A. Potentially.

22 Q. When do you and when don't you?

23 A. It will vary on the numbers of the
24 pharmacy that led to us asking the questions.

1 Q. Okay.

2 A. But if we're asking, we're going
3 to be doing some research on them.

4 Q. Okay. So beyond the data sources
5 that we've spent all of this time painfully
6 talking about, Cardinal has non-quantitative
7 sources of information too, right, meaning you
8 have PBCs or pharmacy consultants who are going
9 out into the pharmacies?

10 A. Yes.

11 Q. And how many sales representatives
12 does Cardinal have?

13 A. Across all classes of drugs,
14 probably 500.

15 Q. How often is a typical pharmacy
16 visited by a Cardinal sales rep?

17 A. It depends on the overall size of
18 the pharmacy and the class of trade, but monthly
19 would be common.

20 Q. And for a large customer, more
21 frequent than monthly?

22 A. Could be.

23 Q. And does Cardinal set any goals
24 for how many pharmacies its sales reps need to

1 visit in a particular period?

2 A. I believe it does. I'm not
3 involved in that process, but I know there's
4 some type of -- all the territories are
5 different sizes. So it's not a flat number.
6 There's a bunch of factors that go into it.

7 Q. Okay. And how many -- and the
8 sales reps who go into pharmacies are instructed
9 to come back to Cardinal with any signs they see
10 of potential diversion?

11 A. Yes.

12 Q. And how many tips do you get from
13 your sales reps in a year about potential
14 diversion?

15 A. We probably get questions from the
16 sales teams weekly.

17 Q. And how many questions?

18 A. It would vary by the week.
19 Sometimes one. Sometimes five. It would
20 depend.

21 Q. Okay. But somewhere in that
22 range?

23 A. Somewhere in that range, I'd say
24 yeah.

1 Q. And has that, by the way, been
2 consistent through your time period in the
3 position?

4 A. It was much more frequent when I
5 initially took over the role just because of
6 continuing to roll out the analytic side of
7 this, that the sales force had to be very
8 involved in evaluating customers and helping us
9 understand certain pieces. So it's leveled off
10 a little bit. Now they understand kind of what
11 a good customer looks like versus a bad
12 customer.

13 Q. And who do those tips or questions
14 come in to?

15 A. It could come in to me. It could
16 come in to anybody on my team. It could come in
17 to a new accounts team if it's a new customer.
18 It could go to one of the field investigators.
19 It could come to anybody.

20 Q. Okay. You don't give standard
21 instructions on what to do with that?

22 A. It often depends on who the person
23 is with the question, if they've got an existing
24 relationship with somebody, or depending on what

1 level they are could determine who they reach
2 out to.

3 Q. Okay. How do those tips or
4 questions come in? Is it by phone, by e-mail,
5 by a form?

6 A. Usually by phone.

7 Q. And have there been any
8 instructions from Cardinal about how sales
9 representatives should document or convey
10 those -- that information?

11 A. As far as like asking questions?

12 Q. Or just conveying concerns.

13 A. I'm not sure if there's a formal
14 structure to it or not. But they know they can
15 raise their hand on any concern they have at any
16 time with any customer.

17 Q. Okay.

18 A. It's been very helpful for them to
19 have the process that we have, because it
20 prevents them from wasting time prospecting a
21 customer that we're going to deny or cut off six
22 months after they come on board. So it's helped
23 them to understand the objective criteria, what
24 to look for to not waste their time trying to

1 bring on somebody that we're going to say no to.

2 Q. And when you say no to a
3 customer --

4 A. Yes.

5 Q. -- do you then convey that
6 information to DEA or the Pharmacy Board, too?

7 A. If we are denying them upfront?
8 No. And it's a tricky process because you might
9 not have all the pieces, or you might get bad
10 information. Then you could upset the customer,
11 and then they don't want to come back and try
12 again because we told them no. So we don't
13 always see all the pieces until -- if they go
14 through the company process.

15 Q. Now, you also talk presumably to
16 manufacturers of opioids about their suspicions
17 about customers, about pharmacies, for instance.

18 A. Yes.

19 Q. And are there particular
20 manufacturers with whom you have those
21 conversations regularly?

22 A. There are. I would say
23 Mallinckrodt is probably the most -- I don't
24 know if "busy" is the right word, but

1 Mallinckrodt is probably the most common.

2 Q. Okay. What was the word you used?

3 A. Busy.

4 Q. Okay. And how long has that been?

5 A. Since I've been in the role.

6 Q. Okay.

7 A. I mean, it could have been before
8 my realm. I'm saying as long as I have been in
9 the role, that's been taking place.

10 Q. Okay. And who has that
11 conversation with Mallinckrodt at Cardinal? Who
12 at Cardinal?

13 A. It could be me -- it depends on
14 what the -- if it's a -- if they want to come
15 and talk to us about specific customers. If
16 they say, "Hey, there's ten customers we want to
17 talk to you about," I'd be involved in that
18 conversation.

19 It could be a one-off, and it
20 could go to somebody in legal. It could go to
21 somebody on my team. If an investigator
22 happened to have been there when someone from
23 Mallinckrodt was there at the same point in
24 time, they might reach out to that person.

1 Q. Do you ever plan site visits
2 jointly with a manufacturer?

3 A. No.

4 Q. And who at Mallinicrodt keeps you
5 busy?

6 A. Don Lohman was probably the person
7 that I corresponded with the most.

8 Q. And has something happened to him?

9 A. No. Something has. I don't know
10 what has exactly changed in his role. I don't
11 know if he's gained more things or been more
12 narrowly focused, but something has changed with
13 Don's job. I'm not sure what it is exactly.

14 Q. But he's not the person anymore?

15 A. I don't want to say he's not, but
16 he might have other people under him now. I
17 think Karen Walker was somebody who I dealt with
18 a lot, too.

19 Q. Okay. What about other
20 manufacturers? Who were you frequently in
21 communication with?

22 A. We've had communication with
23 Purdue. We've had communication, I believe,
24 with J&J. Mallinckrodt is the most common.

1 Q. So if Mallinckrodt is your
2 busiest, how often are you hearing from
3 Mallinckrodt?

4 A. It varies based on -- so it could
5 be a one-off customer. That could be
6 frequently, or it could be once a quarter with a
7 ten-customer type of question. So it really
8 depends on the number of customers more than the
9 frequency that kind of drives it.

10 Q. Can you give a ballpark for how
11 many customers Mallinckrodt has raised with you
12 all?

13 A. Hundreds.

14 Q. Hundreds?

15 A. Yeah.

16 Q. Okay. And then you mentioned
17 Purdue and J&J.

18 A. Yes.

19 Q. How do they compare if we're
20 talking about a number of customers?

21 A. Volume-wise? Not as frequent.

22 Q. So are we talking 25?

23 A. Yeah. Probably someone -- again,
24 they're branded manufacturers. Their volume is

1 much lower.

2 Q. Okay. And who is the contact at
3 Purdue?

4 A. I can't remember the lady's name.

5 Q. And how about Johnson & Johnson?

6 A. I can't remember that person's
7 name either. We have a whole process that legal
8 is involved in. So there's a documentation to
9 the request and those type of things. So it's
10 not just me.

11 Q. Okay. And so who manages that
12 process at Cardinal?

13 A. I don't know who the specific
14 person on the legal team is, but it lives in the
15 legal world.

16 Q. Okay. Does Cardinal give any
17 formal instructions or requests to the
18 manufacturers it buys from to notify it of
19 certain events or circumstances?

20 A. We've had meetings with many of
21 them kind of similar to the DEA meeting to
22 review the program, the components, how it
23 works. So a lot of the takeaways are kind of
24 understood through here's how -- because they

1 meet with all the wholesalers.

2 So they understand how the ABCs
3 and McKessons work as well. So in meeting with
4 us and kind of going through those steps, they
5 understand what the things are that we're
6 looking at and why.

7 Q. Okay. And has that been going on
8 throughout your tenure?

9 A. Yes.

10 Q. And I take it, like DEA, there are
11 PowerPoints that get presented?

12 A. Yes.

13 Q. And do manufacturers have any
14 expectations of you as to what you're reporting
15 to them?

16 A. Manufacturers are in a very unique
17 position because they get to see chargebacks.
18 So they know how much of all of their product is
19 going to a pharmacy from every wholesaler. So
20 they can see pieces that we can't see.

21 They won't tell us who else is
22 supplying how much to them. So they will ask us
23 questions about pharmacies. Because, again, we
24 might only be seeing 20 percent of the volume of

1 that pharmacy, and they can see the other
2 80 percent. So they've got a much better
3 vantage point at the customer level for their
4 product than we do. So they do ask a lot of
5 questions about pieces that we're seeing to try
6 to kind of batch it all together.

7 Q. And does that happen through these
8 formal interchanges?

9 A. Yes.

10 Q. Okay. And you do that with all of
11 the opioid manufacturers?

12 A. Every one that reaches out to us.
13 Again, there's no chargebacks in the branded
14 space. It would only be a generic manufacturer
15 that would see chargebacks.

16 Q. Okay. So name the manufacturers
17 that come to mind.

18 A. As far as?

19 Q. As doing this chargeback and
20 review process.

21 A. Mallinckrodt is the one that comes
22 to mind. There's over 80, I think,
23 manufacturers. And we don't -- we vary which
24 manufacturers we're doing business with. So

1 we're not doing business with all 80 at one
2 time. It could be a different ten today than it
3 is tomorrow based on profitability and
4 contracts.

5 Q. Okay. And in terms of your
6 contract and relationship with manufacturers, in
7 the opioid space, who are your principal
8 suppliers?

9 A. As far as the manufacturers?

10 Q. Yes.

11 A. Oh, it's literally 80 of them.

12 Q. And there are none that stand out
13 above the others?

14 A. No.

15 Q. Okay. And explain how chargeback
16 data gives manufacturers a window -- explain
17 what it is granularly.

18 A. So this is a -- I'm not the expert
19 in this area. So I don't know if you really
20 want me to answer this question. But
21 chargebacks at the manufacturer level get
22 submitted based off of the price the wholesaler
23 pays for the product versus what the customer
24 paid for the product.

1 And if the wholesaler has to --
2 because of a contractual obligation with a
3 customer directly with the manufacturer, if the
4 wholesaler has to sell that product below the
5 wholesaler's contract cost, the manufacturer
6 makes the wholesaler whole. In order to do
7 that, that data has to go to the manufacturer.
8 They can then see how much volume went to which
9 customer from every wholesaler.

10 Q. And who is the expert on
11 chargeback data at Cardinal?

12 A. I don't know. Somebody in
13 purchasing.

14 Q. Okay. Now, we know that
15 Mallinckrodt has sent letters to distributors
16 saying "We want you to look at the following
17 customers" or -- you're raising your eyebrows.
18 So tell me why that is.

19 A. Mallinckrodt doesn't send us
20 letters that say that.

21 Q. Okay. Are you familiar with a
22 letter that Mallinckrodt sent that was filed in
23 Cardinal Health versus Holder?

24 A. I am not.

1 Q. Okay.

2 - - -

3 (Montana-Cardinal Exhibit 2 marked.)

4 - - -

5 Q. So looking at Exhibit 2 --

6 A. Yes.

7 Q. -- beyond the exhibit cover page,

8 is that letter familiar to you?

9 A. No.

10 Q. Okay.

11 A. You got the Karen Harper name

12 right there.

13 Q. Bonus points for that.

14 A. Thank you.

15 Q. So you've never seen a letter like

16 this from Mallinckrodt?

17 A. I'm sorry. Okay. Yes, I have.

18 So that's why I raised my eyebrows. So this is

19 the Mallinckrodt chargeback cutoff letter is

20 what this is.

21 When you asked, you said asking

22 about a customer. So we get these -- they're

23 not asking anything of us. They are telling us

24 that they are no longer going to honor

1 chargebacks for this specific customer or
2 customers.

3 Q. Okay.

4 A. They're not asking anything of us.

5 Q. I'm sorry?

6 A. They're not asking anything of us.

7 Q. Okay. And they notify you of that
8 because it means you're no longer guaranteed --

9 A. Yes.

10 Q. -- from a pricing perspective?

11 A. Exactly.

12 Q. Okay. And what do you do from a
13 compliance perspective when you get a letter
14 like that?

15 A. We cut the customer off from
16 controlled substances.

17 Q. Invariably?

18 A. Invariably.

19 Q. And do you recall getting other
20 letters like that from Mallinckrodt?

21 A. Absolutely.

22 Q. And from other manufacturers as
23 well?

24 A. I don't recall receiving them from

1 any other manufacturer, but definitely from
2 Mallinckrodt.

3 Q. Okay. And the reason Mallinckrodt
4 would cut off a customer from chargebacks is
5 there's something that has made them suspect
6 that customer is engaged in diversion?

7 MS. WICHT: If you know what
8 Mallinckrodt was thinking.

9 A. Yeah. They don't say that in the
10 letter. It just says they will no longer honor
11 chargebacks. Again, knowing they can see all of
12 their volume from all sources to a pharmacy,
13 that's a logical assumption.

14 Q. Okay.

15 A. Which is why we stop selling them
16 controls even though it doesn't tell us to do
17 so.

18 Q. What is the date on that letter?

19 A. Sometime in 2011, September of
20 '11, the year before I left.

21 Q. Okay. And during your tenure, you
22 don't recall similar letters like that from
23 other manufacturers?

24 A. It doesn't mean that I did not

1 receive them. I just know that they don't come
2 with the frequency that Mallinckrodt's do.

3 Q. Okay. And if they did come in,
4 would you be aware of them?

5 A. Yes.

6 Q. Where are those letters? I know
7 that there is a standard operating procedure
8 that refers to these letters. Where are those
9 saved within Cardinal's system?

10 A. That's a good question. Because
11 Mallinckrodt is nice enough to send this to a
12 ton of people, and they BCC everybody. So I
13 don't know who all it goes to. But then I will
14 have ten different people in the purchasing that
15 receive this and forward it to me. So any time
16 a letter comes out, I usually get about 20
17 copies of it.

18 Q. And then what do you do -- where
19 does it get stored?

20 A. We keep a file of -- a record of
21 the Mallinckrodt letters of the customers.
22 Because, again, there's no information on here
23 that's specific to the customer other than the
24 fact they've been put on the list. Mallinckrodt

1 also takes them off the list. So you could get
2 a letter a year later that says they've taken
3 the customer off the list. That's very common
4 as well.

5 Q. Okay. And then so what do you
6 do --

7 MS. WICHT: Can we take a break
8 whenever you're at a pausing point?

9 MS. SINGER: Of course.

10 BY MS. SINGER:

11 Q. And so when you get a letter that
12 a customer has been reinstated, what do you do
13 with that customer?

14 A. Do a site visit.

15 Q. Always?

16 A. Yes.

17 Q. And then?

18 A. And then determine if it's
19 somebody we're comfortable distributing
20 controlled substances to or not.

21 Q. And do you recall how many times
22 that has happened?

23 A. Taken off the list?

24 Q. No. Evaluated to put back on the

1 list.

2 A. Oh, any time they get taken off,
3 we'll evaluate -- well, that's not true. There
4 are oftentimes where we have terminated sales of
5 controls to a customer prior to the letter. So
6 if we cut you off for our concerns, I don't care
7 if we got a letter or not from Mallinckrodt to
8 turn you back on, we'll turn you back on.

9 Q. Okay. So can you give me a rough
10 estimate of how many times you've heard that a
11 customer is back on the chargeback good standing
12 list?

13 A. Sure. Twenty. And that's a swag.

14 Q. And do you know roughly how many
15 of those you've ended up resuming business with?

16 A. I don't. But there have been
17 some.

18 Q. And you've talked about
19 manufacturers notifying you of customers, either
20 in these meetings or through the chargeback
21 process.

22 Are there times when Cardinal has
23 called a manufacturer and said, "Wow. We think
24 there's something crazy happening with Smith's

1 Pharmacy"?

2 A. I know we've had conversations
3 with Mallinckrodt and Purdue about specific
4 customers.

5 Q. And how -- why have you initiated
6 it with those customers and those manufacturers?
7 What is it about them?

8 A. One, we know they're willing to
9 have those discussions with us. And those are
10 two companies that come to mind that have
11 actually have come down and sat down with us and
12 talked about a process and reviewed our program.

13 Q. And do you recall how many times
14 you've done that; referred a customer to a
15 manufacturer?

16 A. I don't. Again, a lot of the
17 conversations have taken place from the legal
18 department's perspective where they've had those
19 conversations and then circled back with me.

20 Q. And has a manufacturer come to you
21 and said, "You're planning to cut off Smith's
22 Pharmacy. They're a really good customer for
23 us. I think you're misreading the data"?

24 A. We've had --

1 MS. WICHT: Has that ever
2 happened? Is that what you're --

3 MS. SINGER: (Indicates
4 affirmatively.)

5 MS. WICHT: Okay.

6 A. We've had manufacturers reach out
7 and complain to us about thresholds.

8 Q. Okay. Which manufacturers?

9 A. I can't remember. And a lot of
10 them haven't been opioid manufacturers. They've
11 been other controlled substances. A
12 manufacturer would not know if we were getting
13 ready to cut a customer off. We'd just cut them
14 off. We wouldn't reach out before making a
15 decision. If we see anything that concerns us,
16 we take action.

17 Q. Okay. So have any of them reached
18 out to you after you took action to say, "That's
19 a problem. Why did you do it? Reconsider."

20 A. No.

21 Q. And you say that some
22 manufacturers, not necessarily of opioids, have
23 raised concerns about thresholds. Do you recall
24 whether any opioid manufacturers have raised

1 concern about thresholds?

2 A. I don't think any opioid
3 manufacturers have.

4 Q. And now Cardinal has marketing
5 agreements with various manufacturers. Is that
6 something that you're aware of?

7 A. No.

8 Q. Do you get any data from marketing
9 efforts that Cardinal undertakes with
10 manufacturers for your compliance efforts?

11 A. Can you be more specific?

12 Q. So is there any data you get from
13 various marketing programs that Cardinal is
14 running that you use in evaluating a customer or
15 otherwise looking at diversion?

16 A. Give an example of what that type
17 of data would be.

18 Q. So Cardinal runs copayment
19 programs --

20 A. Oh, gotcha.

21 Q. -- or adherence programs.

22 A. Yes. No, there would be no data
23 that would come out from that.

24 Q. Okay. Have you ever asked about

1 getting access to that data?

2 A. I'm not sure what -- I follow what
3 data that would be.

4 Q. I mean, presumably that -- I'm on
5 the outside here. There are customer lists and
6 initiative -- things that Cardinal gets and then
7 is in touch with either patients or pharmacies,
8 right? Does that data ever get filtered back to
9 you?

10 A. Like distribution data?

11 Q. I mean, again --

12 A. I'm not sure what the data would
13 be that would be the output of that.

14 Q. So you would be in the best
15 position to know --

16 A. I don't think there is any data
17 that would be driven off of that. I don't
18 think. And if there is, I haven't seen it.

19 Q. Okay. Almost done with this
20 section.

21 Is there any source of data or
22 information that you use in your compliance
23 efforts that we haven't talked about?

24 A. The only other piece would be the

1 data that we collect at the aggregate level when
2 we do site visits.

3 Q. Okay. And tell me what you mean
4 by that.

5 A. So when we perform a visit on a
6 customer, we go in and we're capturing a lot of
7 the context pieces that I had referred to
8 earlier to see what that total picture looks
9 like. We capture that information at the time
10 of the visit.

11 Q. Okay. And are you talking about a
12 questionnaire?

13 A. No. We're talking about when an
14 investigator goes in. The pharmacy runs reports
15 while the investigator is there and gets the
16 information.

17 Q. Okay. So if the investigator has
18 gotten dispensing data --

19 A. Yes.

20 Q. -- or prescriber data?

21 A. Yeah. They collect aggregate
22 level dispensed, so total scripts, control,
23 non-control, total oxycodone pills, total
24 hydrocodone pills, those type of things.

1 Q. And does that get filtered into
2 that customer's profile, or is it used more
3 broadly by Cardinal?

4 A. Customer's profile, absolutely.

5 Q. And not more broadly?

6 A. It is already incorporated into
7 the more broad data.

8 Q. Through the other data source?

9 A. Yes, exactly.

10 Q. Okay. Have you ever used an
11 outside vendor to assess whether there's other
12 data that Cardinal could be mining in its
13 compliance efforts?

14 A. A vendor? No.

15 Q. Any kind of consultant?

16 A. Not that I'm aware of.

17 Q. Okay. Have you ever worked with
18 anybody outside of Cardinal to advise you on how
19 to use the data you have more effectively for
20 compliance?

21 A. Yes.

22 Q. And who's that?

23 A. Linden Barber.

24 Q. Before he was with you?

1 A. Yes. He was outside.

2 Q. Okay. And in what entity was he?

3 A. He was, I believe, outside
4 counsel.

5 Q. Okay. All right. And have there
6 been any proposals you've received for other
7 data sources or other ways of using data you've
8 rejected?

9 A. Not that I'm aware of.

10 Q. Okay. And any data which you've
11 had that Cardinal has said, "Nah, too expensive"
12 or "We don't need it"?

13 A. I wish they could push down the
14 overprescribing. That would help.

15 Q. Have you ever talked to other
16 distributors about particular customers?

17 A. About particular customers? No.

18 Q. Customers you've terminated or
19 rejected?

20 A. No.

21 Q. Have you ever talked about data
22 sources on any of these HDA calls or
23 conferences?

24 A. Not on the calls that I've been

1 on, no.

2 Q. Or with HDA generally?

3 A. No. And, again, I don't speak to
4 HDA a ton. Again, there are so many different
5 Cardinal groups that interact with HDA. I'm
6 only a small portion of it.

7 MS. SINGER: Okay. We can take a
8 break now.

9 THE WITNESS: Thank you.

10 (Recess taken.)

11 BY MS. SINGER:

12 Q. All right. So, Mr. Cameron, you
13 remain under oath.

14 A. Yes.

15 Q. Okay. SOP is Cardinal terminology
16 for?

17 A. Standard operating procedure.

18 Q. So, as I understand it, an SOP is
19 what lays out the procedure across the country
20 on a particular process or topic; is that right?

21 A. Yes.

22 Q. And it's how Cardinal communicates
23 a policy or a procedure across the organization
24 or across a division; is that correct?

1 A. Yes.

2 Q. Okay. So if an employee wanted to
3 figure out what to do on a particular issue,
4 they would go to the SOP, and it would tell them
5 how to handle it?

6 A. Yes.

7 Q. And you train your employees on
8 relevant SOPs; is that correct?

9 A. We do.

10 Q. And then SOPs are updated and
11 replaced and reviewed periodically. Is that
12 true as well?

13 A. Yes.

14 Q. Okay. And are employees who don't
15 follow SOPs, like, subject to discipline? Is
16 this an important expectation?

17 A. Yes.

18 Q. In 2006 Cardinal and other
19 distributors received a letter from the Office
20 of Diversion Control about suspicious order
21 monitoring and anti-diversion efforts signed by
22 Joe Rannazzisi. I assume you know what I'm
23 referring to?

24 A. I do.

1 Q. And so -- I know this was before
2 you were in your current position. But do you
3 know what Cardinal's response to that first 2006
4 letter was?

5 A. As far as a response to DEA?

6 Q. And let me clarify. I don't mean
7 if you sent a responsive letter. But what did
8 Cardinal do or change in response to that letter
9 as a result of that letter or following on that
10 letter?

11 A. At that point in time, I was not
12 involved in the area in 2006 when the letters
13 were received. So I'm not sure what changes
14 would have taken place at that specific point in
15 time.

16 Q. And when you moved into your
17 position and acclimated yourself within the job,
18 is that not something you came across?

19 A. I know that a lot of the changes
20 that had been made prior to my arrival had
21 connectivity back to those letters.

22 Q. And how do you know that?

23 A. Because we talked about a lot of
24 the components within the letters.

1 Q. And who is "we"? The people you
2 consulted?

3 A. Yeah, exactly.

4 Q. Okay. And so what did they say
5 that connected those dots for you?

6 MS. WICHT: I will just give you a
7 caution here, because I think, as I
8 understand it, that at least some of
9 those conversations would have been with
10 lawyers.

11 To the extent that you were
12 getting -- that Cardinal was getting
13 legal advice from lawyers on that, you
14 shouldn't reveal that.

15 If there are things that you know
16 were done or discussed that weren't from
17 lawyers, then you're free to reveal
18 that.

19 A. I know that there are multiple
20 letters. So I'm not sure which letter
21 sequentially included which. But I know there
22 are components in the letter that talk about
23 some of the objective pieces that we use to
24 evaluate customers.

1 Q. Okay. Meaning that Cardinal took
2 queues from those letters and made changes in
3 its SOPs or policies after those letters?

4 A. I don't know if they took the
5 queues from the letters or if those were things
6 that they looked at prior to the letters,
7 because I came so much later than letters. I
8 just know that some of the things in the letters
9 are components of the program.

10 Q. Okay. Have you seen a report that
11 was done to Cardinal's board in 2013 in
12 connection with a shareholder lawsuit against
13 the company?

14 A. Yes.

15 Q. Okay. And is it accurate,
16 consistent with that report, that prior to 2008
17 Cardinal did not have an electronic system for
18 detecting and reporting suspicious orders?

19 A. I'm not sure.

20 Q. Okay. Have you seen any evidence
21 that Cardinal did have such a system?

22 A. I've not seen any components of
23 the program back at that point in time.

24 Q. And do you -- Cardinal started

1 using thresholds in 2008; is that right?

2 A. I'm not sure.

3 Q. And do you know how Cardinal
4 reported suspicious orders or identified them
5 prior to 2008?

6 A. I do not.

7 Q. Are you familiar with excessive
8 purchase reports?

9 A. I'm familiar with the concept.

10 Q. Okay. What is it?

11 A. There was a reporting mechanism
12 that wholesalers were required to run I think at
13 the end of every month that was an algorithm
14 that came from DEA that identified shipments
15 that DEA wanted information on about customers.

16 Q. Okay. So, as you understand it,
17 an excessive purchase report was run on
18 customers that DEA identified with an algorithm
19 they used, or were they customers identified
20 through DEA's algorithm?

21 A. DEA made the algorithm. And then
22 the wholesaler ran the algorithm, and whatever
23 customers came out of being identified from the
24 algorithm, that information went to DEA.

1 Q. Okay.

2 A. That's my understanding.

3 Q. Okay. And was there any
4 suspicious order monitoring system, to your
5 knowledge, apart from the excessive purchase
6 reports?

7 A. I don't know.

8 Q. Did Cardinal have any procedure in
9 place not to ship orders identified in those
10 excessive purchase reports, to your knowledge?

11 A. Again, I've got a very limited
12 knowledge of what those reports were. But my
13 understanding is the wholesaler was supposed to
14 run them on distributions that were made.

15 Q. Meaning that since they were
16 already made, there could be no stopped
17 shipment?

18 A. That's my understanding.

19 Q. Okay. Now, as you understand it,
20 reporting a suspicious order is not the full
21 scope of Cardinal's duty under the Controlled
22 Substances Act or implementing regulations?

23 A. Ask me that again. Sorry.

24 Q. Cardinal has to do more to comply

1 with the law than just report a suspicious
2 order?

3 A. Yes.

4 Q. Is that correct?

5 A. I believe so.

6 Q. Okay. Do you have any hesitance
7 about that?

8 A. I was only hesitating just from
9 the standpoint of when you started to ask, I was
10 thinking about the reg itself around designing
11 and operating the system to identify suspicious
12 orders, and I was thinking about the specific
13 reg. That's why I was hesitating.

14 Q. Okay. So it is a duty -- and
15 correct me if I'm misstating this -- to detect,
16 report, and prevent suspicious orders? Is that
17 a correct statement as you understand it? Or
18 put it in your own words.

19 A. The reg specifically says that the
20 wholesaler -- that the registrant shall design
21 and operate a system to identify orders of
22 varying frequency, size, and pattern.

23 Q. And report them promptly, report
24 them immediately to DEA?

1 A. I don't think the reg says that.

2 That's why I was hesitating. We do, but that's
3 what I thought.

4 Q. Okay. And Cardinal has
5 responsibility under the law to design and
6 operate a system that places effective controls
7 to prevent diversion?

8 A. Yes.

9 Q. Okay. And that is in addition to
10 suspicious order reporting, correct?

11 A. I believe so.

12 Q. Okay. So just having suspicious
13 order reports doesn't fully discharge your duty?

14 A. Yes. I'm not sure about the word
15 "duty" in all that, but yes.

16 Q. Okay. Do you know if there was an
17 SOP for stopping shipping of suspicious orders
18 prior to 2008?

19 A. I do not know.

20 Q. When are you aware that Cardinal
21 first had a procedure in place to stop shipping
22 suspicious orders?

23 A. I do not know the specific date,
24 but I know that it was well before my arrival.

1 Q. Who was responsible for
2 anti-diversion compliance from 2006 forward?

3 You mentioned your predecessor. Was there
4 anybody else who had held that role?

5 A. I'm not sure. I don't know.

6 Q. Okay. So the name you gave
7 before, I think, was Mr. Mone?

8 A. Yes.

9 Q. And is there anybody else you're
10 familiar with who had a senior role in
11 compliance before that?

12 A. I'm not, but it doesn't mean that
13 person didn't exist. I just had no dealings
14 with that area.

15 Q. Are you familiar with the outside
16 vendor -- I'm sure I'm going to butcher the
17 name. So you know where I'm going. Cegedim
18 Dendrite.

19 A. Yes.

20 Q. Did I say it right?

21 A. I don't know how to say it right
22 either, so yes. That was good.

23 Q. So for us, that's what it's going
24 to be.

1 A. I just call them Cegedim.

2 Q. Or we can go with Dendrite. How's
3 that?

4 A. There you go. That's even easier.

5 Q. So what was their role in the
6 suspicious order monitoring system at Cardinal?

7 A. So I apologize. I don't -- there
8 has been a lot of movement in the industry from
9 a company standpoint. So I'm not sure if
10 Cegedim is part of other companies or spun off
11 or got absorbed. A lot of that part of the
12 industry has moved around a lot. But they, I
13 know, were used at one point in time to do site
14 visits.

15 Q. Okay. And are you familiar with a
16 role they played in developing the threshold
17 system at Cardinal?

18 A. I am not.

19 Q. Okay. You've never seen any
20 documents related to their work?

21 A. Other than visits, no.

22 - - -

23 (Montana-Cardinal Exhibit 3 marked.)

24 - - -

1 Q. All right. Mr. Cameron, showing
2 you Exhibit 3, which is SOP -- the SOP on -- why
3 don't you read the title.

4 A. "Process to Establish SOM
5 Threshold Limits."

6 Q. Okay. Are you familiar with that
7 SOP? Whenever you're ready.

8 A. I am not.

9 Q. Either that iteration or any of
10 the later forms of it?

11 A. Definitely not this iteration.

12 Q. Okay. Have you seen it in
13 subsequent forms?

14 A. There are SOPs today around seven
15 thresholds.

16 Q. Okay. And it seems like that this
17 is a new -- that this is not a document or a
18 version of a document you're terribly familiar
19 with; is that right?

20 A. Correct.

21 Q. And how is that?

22 A. How is that the case --

23 Q. Yes.

24 A. -- or how am I not familiar with

1 it?

2 Q. So is it that SOPs, like our
3 personnel manual at my law firm, sit on the
4 shelf, or is it because -- I mean, tell me how
5 that is.

6 A. I know the SOPs are updated
7 periodically and reviewed periodically. When I
8 look at, for example, 0001169, I'm not sure what
9 all that stuff is. As I read that, I'm assuming
10 that's got something to do with the DEA
11 algorithm from the previous stuff you were
12 asking about earlier.

13 Q. Okay.

14 A. That's my assumption.

15 Q. Okay. But the later version of
16 this that's current is not something that sits
17 on your desk and you refer to when you have a
18 question? It doesn't sound that way.

19 A. It would depend on what was being
20 discussed, the situation. We use our working
21 guidelines much more.

22 Q. And what are the working
23 guidelines?

24 A. I would describe them as more

1 action oriented details around what's in the
2 SOPs.

3 Q. So it's a level of detail beyond
4 an SOP that are more day-to-day practical?

5 A. Yes.

6 Q. Okay. Do you know where the idea
7 of using thresholds for suspicious order
8 monitoring came from?

9 A. I do not.

10 Q. Mystery.

11 A. They were there when I got there.

12 Q. Okay. And you never asked anybody
13 why; why does our system turn on this?

14 A. Why does our system do what?

15 Q. Turn on thresholds. Why are they
16 such a central part of Cardinal's compliance
17 system? Why do we use thresholds?

18 A. Oh, I understood that it was to
19 limit the volume of controlled substances that
20 were distributed.

21 Q. Okay. And do you know why the
22 thresholds were the mechanism for doing that?

23 A. I don't know that I ever thought
24 about it.

1 Q. Okay. When you first joined the
2 compliance side of Cardinal, how many people
3 were on the staff there?

4 A. I'm not sure.

5 Q. Can you give a rough estimate?
6 Was it 20, 100, 200?

7 A. For all of compliance?

8 Q. Yes.

9 A. Hundreds.

10 Q. Below 500?

11 A. I don't know.

12 Q. And how is it -- what is the size
13 of compliance now?

14 A. Hundreds.

15 Q. Larger or smaller than it was when
16 you first started?

17 A. I would say larger.

18 Q. Significantly larger?

19 A. I don't see all the areas of
20 compliance because I'm not involved in them. So
21 I don't know how much larger it's grown.

22 Q. Okay. So what is your area of
23 compliance?

24 A. The anti-diversion controlled

1 substance monitoring program.

2 Q. Okay. And is that a division
3 within the compliance department?

4 A. Yes.

5 Q. Okay. And how many people were in
6 that division when you joined it?

7 A. I don't know the exact number, but
8 it's -- we are definitely bigger today than we
9 were when I started.

10 Q. Okay. And so it's some subset of
11 the hundreds. I mean, again, are we talking
12 dozens? Are we talking --

13 A. As far as the increase?

14 Q. How many people were there in 2012
15 when you -- well, yeah.

16 A. Maybe -- I've never thought about
17 it, so I'm sorry.

18 Q. It's okay. I would say you're not
19 a numbers person, but you're clearly a numbers
20 person.

21 A. But I just -- the bodies, I hadn't
22 thought about what it was then versus what it is
23 now. Because, again, when I came in, they had
24 already started to make changes to the program.

1 So a lot of the pieces were moving when I got
2 there. I don't know the exact numbers, what
3 they were back then.

4 Q. Okay. And so you don't know the
5 head count now either?

6 A. I don't. I guess -- can you ask
7 me exactly what area you're asking me about?

8 Q. So I'm asking the anti-diversion
9 effort that you are responsible for.

10 A. My area specifically?

11 Q. Yes.

12 A. Okay. And what's the question?

13 Q. How many people work in it?

14 A. About 35.

15 Q. Okay. And their responsibilities
16 are to run what areas of the anti-diversion
17 effort?

18 A. The controlled substance
19 monitoring.

20 Q. Okay. And so that's data
21 analytics --

22 A. Yes.

23 Q. -- and investigations?

24 A. Yes.

1 Q. What other functions?

2 A. Know Your Customer.

3 Q. Okay. Anything else?

4 A. Those are the three main
5 components.

6 Q. And how is your staff divided up
7 among those three?

8 A. You want actual numbers?

9 Q. Just roughly. You know, most
10 people are in investigations or --

11 A. It's pretty equally spread across
12 the segments.

13 Q. Okay. And do all of the
14 investigators who go out and do site
15 inspections, for instance, work in your unit?

16 A. Yes.

17 Q. And all of the data analytics on
18 the compliance side as opposed to the sales or
19 marketing side?

20 A. Yes.

21 Q. Now, thresholds are set for each
22 drug family, correct?

23 A. Correct.

24 Q. And so oxycodone has its own

1 threshold, and fentanyl would be different for a
2 particular customer?

3 A. Yes.

4 Q. Do you set threshold at the dosage
5 level as well?

6 A. Yes.

7 Q. So there's a threshold for
8 oxycodone 80 milligrams, a threshold for
9 10 milligrams?

10 A. For oxycodone, there's a threshold
11 at the DEA base code level, which is all
12 oxycodone family.

13 Q. And so where does dosage come in?

14 A. At that level.

15 Q. Okay. Meaning the DEA base code
16 incorporates dosages?

17 A. Yes.

18 Q. Okay. And so you would have a
19 different threshold potentially for the
20 80-milligram dose and the 10-milligram dose?

21 A. No, we would not. It would all be
22 part of the oxycodone family.

23 Q. So that threshold is going to
24 apply to every base code within that family?

1 A. That's all the same base code.

2 It's all the oxycodone base code.

3 Q. I confounded you with numbers.

4 Now you're getting me.

5 A. Sorry.

6 Q. That's okay. So let's take

7 oxycodone has a base code.

8 A. Yes.

9 Q. You're going to set a threshold
10 for Smith's Pharmacy of 40,000 dosage units.

11 A. Yes.

12 Q. And that's going to apply for the
13 80-milligram, the 60-milligram, et cetera?

14 A. All oxycodone.

15 Q. Okay. And then do those all get
16 added up into a master threshold for oxycodone,
17 meaning you can do 10,000, whatever I said, of
18 the 60, 10,000 of the 40, et cetera?

19 A. Yes.

20 Q. Okay. What happens if you do
21 20,000 of the 20? Can you make that up in 40s?

22 A. What do you mean by "make it up"?

23 Q. Meaning -- sorry.

24 If you come in below a threshold

1 at a particular dosage unit, can you pick it up
2 in a different dosage unit?

3 A. When you say "different dosage
4 unit," you mean --

5 Q. Yes. You're right. A different
6 dose.

7 A. So all oxycodone is in the same
8 oxycodone DEA family.

9 Q. Mm-hmm. So I'm sorry for not
10 understanding you. But within the oxycodone
11 family, we have a series of doses?

12 A. Yes.

13 Q. Each of those has its own
14 threshold?

15 A. No. All oxycodone.

16 Q. Has a threshold?

17 A. Yes.

18 Q. And you can mix it up however you
19 want within that threshold so as long as you
20 stay within it?

21 A. At the oxycodone level, yes.

22 Q. Okay. And then there's a separate
23 one for hydrocodone?

24 A. Correct. Yes, exactly.

1 Q. And I take it there are no
2 distinctions, for instance, if you order an
3 abuse-deterrent formulation versus a non-abuse
4 deterrent formulation for a threshold purpose?

5 A. Within the oxycodone family, we do
6 have a subbase code that is focused on the
7 non-abused deterrent formulation. So there's a
8 second threshold underneath the total oxycodone
9 threshold.

10 Q. Okay. And are there any other
11 subcodes beyond that for ADF formulations?

12 A. Yes.

13 Q. And what are those? Is this a
14 rabbit hole I'm going to regret going down?

15 A. No, no, no. Oxycodone is the most
16 common. There are instances where we could use
17 one within hydrocodone. We can use one with
18 alprazolam. We can use one -- we do use one
19 within buprenorphine. We use one within
20 fentanyl. Those are the most common ones.

21 Q. Okay. And there are subcodes
22 you're saying within those for abuse-deterrent
23 formulations?

24 A. Or lack thereof.

1 Q. Okay. And are there other
2 subcodes that aren't abuse-deterrent
3 formulations?

4 A. Meaning are there other drugs I
5 didn't say just now?

6 Q. Meaning are there other subcodes
7 within a class beyond ADF?

8 MS. WICHT: That aren't based on
9 whether the drug is ADF?

10 MS. SINGER: That's right. Thank
11 you.

12 A. And I would tell you that the base
13 code and subbase code isn't necessarily based on
14 ADF or not. It's just based on what we know to
15 be potentially the more commonly abused strength
16 within that family.

17 Q. So why do you create these
18 subcodes? What impact do they have on
19 threshold?

20 A. One of the things that we learned
21 from Linden when he came on is that --

22 MS. WICHT: Linden is a lawyer,
23 and I can't -- I can't tell whether what
24 you're about to convey is something

1 that's legal advice from Linden or not.

2 THE WITNESS: I might be. It
3 probably is.

4 MS. WICHT: So you can't reveal
5 legal advice that came from Linden.

6 BY MS. SINGER:

7 Q. It's overbroad, but -- without
8 talking about the source of knowledge, what I'm
9 asking you is, why would you distinguish certain
10 formulations or dosages within a drug family?
11 What impact does that have and why?

12 A. It goes back to the concept we
13 talked about earlier around evaluating the
14 customer, the total size, the context of the
15 size, the ratios within certain controlled
16 substances. That's where -- that's how we use
17 the subbase codes.

18 Q. Okay. So, again, that's --
19 conceptually that makes sense, but tell me how
20 that works in practice.

21 So within oxycodone, what subcodes
22 do you have? Is there something you lower
23 threshold on because it is more highly diverted
24 or abused? Is there something you have a higher

1 threshold because it's less diverted?

2 A. So you have an oxycodone threshold
3 that would be all oxycodone. And then beneath
4 that, you would have a lower threshold that
5 would be for your oxycodone 15 and 30-milligram.

6 Q. Okay. Because those are highly
7 diverted?

8 A. I wouldn't call them highly
9 diverted. But those are the more commonly
10 diverted when a form of oxycodone is diverted.

11 Q. Okay. And, again, I don't want to
12 spend much more time on this. And we're going
13 more slowly.

14 Within our -- let's say our
15 Smith's Pharmacy has a 60,000 threshold for
16 oxycodone.

17 A. Yes.

18 Q. Within that, you might have a
19 subunit that says, "But only 20,000 of that can
20 be 30 milligrams"?

21 A. Yes.

22 Q. Okay. Are there other subcodes
23 other than dosage and ADF that you use to
24 identify more commonly diverted drugs?

1 A. What do you mean when you say
2 "other than dosage"? Because every threshold is
3 set based off a dosage amount.

4 Q. Okay. So you just said that you
5 might have a lower threshold for 30 or
6 15 milligrams.

7 A. Dosage.

8 Q. Yeah.

9 A. Yes.

10 Q. Okay. So are there other
11 categories like that where you adjust how you're
12 treating threshold to account for more common
13 diversion?

14 A. Yeah. Those are the examples I
15 gave earlier; the buprenorphine, those.

16 Q. Okay. But what within them?

17 A. Like what specific strength?

18 Q. Meaning within them you're going
19 to have various dosages --

20 A. Yes.

21 Q. -- that signal the greater
22 likelihood of diversion, but it's all dose
23 related?

24 A. Exactly.

1 Q. Okay.

2 A. Yes.

3 Q. Do you set thresholds differently
4 within parts of the country or parts of a state
5 that have known diversion problems, like West
6 Virginia or Kentucky, for instance, and then
7 higher in Montana?

8 A. No. We evaluate each customer
9 independently.

10 Q. Okay. So whether an area has
11 greater incident of diversion or less, the
12 threshold is going to drive up from the
13 customer, not from the context geographically?

14 A. Yes.

15 Q. Have you ever seen the HDA's
16 industry compliance guidelines?

17 A. I'm not sure.

18 - - -

19 (Montana-Cardinal Exhibit 4 marked.)

20 - - -

21 Q. All right. Looking at Exhibit 4,
22 HDMA, then "Industry Compliance Guidelines,
23 Reporting Suspicious Orders and Preventing
24 Diversion of Controlled Substances."

1 Have you seen this guide before?

2 A. I'm not sure if I've seen it in
3 this exact format or not.

4 Q. All right. Are you familiar with
5 the substance of these guidelines?

6 A. I know that our regulatory legal
7 team is constantly reviewing these types of
8 things and coming to us around the program.

9 Q. To ask for your feedback?

10 A. It would depend on the subject.
11 It could be to ask for feedback. It could be to
12 give us information of things that are changing.

13 Q. Okay. All right. If you turn to
14 page 8. About halfway down the page,
15 "Distributors are also encouraged to consider
16 the following when developing thresholds ..."

17 A. Yes.

18 Q. If you look at the second bullet,
19 it encourages distributors "to ascertain changes
20 in diversion patterns or emerging local or
21 regional concerns. Such new information may be
22 used to adjust thresholds as appropriate."

23 Do you all do that? It doesn't
24 sound consistent with what you're describing.

1 MS. WICHT: Which set of bullets
2 are you in?

3 MS. SINGER: The second page under
4 "Distributors are also encouraged."

5 MS. WICHT: Oh, I see. And you
6 read the second part of it?

7 MS. SINGER: Yes.

8 MS. WICHT: Okay. Thank you.

9 BY MS. SINGER:

10 Q. That's just not guidance that
11 Cardinal follows; is that correct?

12 A. And which part -- the six-month's
13 sales history or reaching out to the DEA?

14 Q. The reaching out to DEA and
15 looking at regional variations.

16 A. We are definitely aware of
17 regional variations across the country.

18 Q. But you don't incorporate them in
19 thresholds, because those are customer-based?

20 A. We incorporate them in the
21 customer evaluation.

22 Q. Do you incorporate them in setting
23 a customer's thresholds?

24 A. We incorporate them in evaluating

1 the customer, and then that evaluation dictates
2 the thresholds.

3 Q. So what I'm asking you is if you
4 knew that in Whitefish, Montana there was a
5 problem with Opana, diversion and injection,
6 would you then look at Smith's Pharmacy in
7 Whitefish and say, "We're lowering the Opana
8 threshold because Whitefish has an Opana
9 problem"?

10 A. If we knew that Opana was a very
11 uncommonly prescribed drug in that area and a
12 customer was high from that drug, we would ask
13 questions to understand why.

14 Q. Right. But I don't think that's
15 responding to my question.

16 Would you use it in setting that
17 customer's threshold?

18 A. Yes.

19 Q. And can you think of an example
20 where you've done that?

21 A. Oh, gosh. A specific customer
22 example?

23 Q. Or a region that you knew --
24 right? That there was a problem with a

1 particular drug, so you lowered all your
2 customers in that area's thresholds for that
3 drug?

4 A. When we evaluate a customer, if
5 the prescribing that is driving the dispensing
6 into that area is out of the norm for that area,
7 that would constitute a review of the customer.
8 We would make a decision on how we should handle
9 that customer differently.

10 Q. Okay. When you say "evaluating
11 customer and handling that customer
12 differently," are you talking specifically in
13 how you set a threshold for that customer?

14 A. Yes.

15 Q. Okay. And so -- but you can't
16 think of a specific example where you've done
17 that with a drug or a region?

18 A. I know we've done that thousands
19 of times.

20 Q. Okay. And tell me how to
21 reconcile that with your earlier statement that
22 you're looking at a customer's order history and
23 building out threshold from that.

24 A. I never said looking at a

1 customer's order history in setting thresholds.

2 Q. Okay.

3 A. I didn't say that.

4 Q. Okay. So tell me -- again, I'm
5 just trying to get what you do.

6 A. I'm just trying to follow the
7 question. Sorry.

8 Q. Okay. So tell me how that works
9 in setting threshold.

10 A. How what works?

11 Q. How you -- what factors you take
12 into account.

13 A. We evaluate the customer, the
14 business model, the overall context, the
15 variations within specific controlled substances
16 for that customer and specific strengths of
17 controlled substances for that customer.

18 Q. And you do that for every
19 customer?

20 A. Correct.

21 Q. For every controlled substance
22 they buy?

23 A. Correct.

24 Q. And you do that when they onboard,

1 or you do that then again periodically?

2 A. Both, yes.

3 Q. And how often do you do that?

4 A. Depends on the customer.

5 Q. And how do you decide?

6 A. The ratios and volumes of the
7 customer, threshold events, those types of
8 things.

9 Q. Okay. And who decides what the
10 threshold is going to be for a customer?

11 A. It depends on the customer and the
12 size of the customer.

13 Q. Okay. So large customer, who does
14 that?

15 A. It goes up to a legal group.

16 Q. And so who decides in the first
17 instance?

18 A. It depends on the size.

19 Q. For a large customer?

20 A. It could be -- it could have to go
21 to that group prior to turning the customer on.
22 That's very common.

23 Q. Okay. But somebody has made a
24 recommendation in the first instance and says,

1 "Here's what I think the threshold would be for
2 Walgreens in Billings."

3 A. Depending on the size, somebody
4 might not make a recommendation. We would get
5 in the room and review all the factors I talked
6 about earlier and make a decision.

7 Q. Okay. And who's that group that's
8 doing that then?

9 A. That's the large volume tactical
10 and analytical committee.

11 Q. Okay. And if it's an independent
12 pharmacy that's a smaller pharmacy, who does it
13 then?

14 A. Depends on the size of the volume.

15 Q. Okay. So if it's a mid size
16 pharmacy?

17 A. It would depend on -- when you say
18 "mid size," mid size for which drug?

19 Q. For oxycodone.

20 A. There are multiple levels of
21 escalation across the team that determines who
22 has to approve it.

23 Q. Okay. So hugely complicated,
24 obviously?

1 A. Yes.

2 Q. So sales rep comes in. They're
3 excited. They've signed up or they want
4 approval for a new customer in Montana. How do
5 you all decide and based on what their threshold
6 is going to be?

7 A. So the customer completes the Know
8 Your Customer questionnaire that gathers the
9 information that we need to review the customer.

10 At that point in time, we
11 determine, is this a customer that we want to do
12 business with? If so, at what levels? And then
13 that's when we would set the thresholds.

14 Q. Okay. And is this done through an
15 algorithm? Is it done by, you know, subjective
16 determinations based on factors? What --

17 A. It's based on that review of the
18 customer to determine what volumes we're
19 comfortable with, and then you compare that to
20 what volumes they need.

21 Q. So is this something that is made
22 based on an individual employee's skill and
23 experience? Is it something that's driven by a
24 set of criteria and formulas?

1 A. It's driven initially by the
2 concept of the formulas. But then depending on
3 the volume, the group has to review it.

4 Q. Okay. How many new customers is
5 Cardinal bringing on with controlled substances
6 privileges every month?

7 A. I don't know the exact number.
8 Maybe 50.

9 Q. And you're going through this
10 detailed process for each of them?

11 A. Yes.

12 Q. And then for those that have been
13 identified as warranting further assessment?

14 A. Yes. Yes.

15 Q. And for a large customer who has
16 approval on the threshold, who has final
17 decision?

18 A. Oh. It depend on how large. But
19 if it's at the largest end of our spectrum, it
20 would be the LV TAC group.

21 Q. And you mentioned before that you
22 have a level more detailed than SOPs. I forget
23 what you called it.

24 A. Working guidelines.

1 Q. Okay. Do you have a working
2 guidance that lays this out?

3 A. It may not in the manner in which
4 you're asking the questions. But, yeah, all the
5 components are there.

6 Q. Okay. And which working guidance
7 is this?

8 A. I don't know. You asked questions
9 across a lot of them.

10 Q. Okay. Tell me which areas it
11 covers. So which guidances would we need to put
12 the pieces together here?

13 A. Probably all of them that you
14 have.

15 Q. And how many of them are there?

16 A. I don't know the exact number.

17 Q. Okay. Give me some of the subject
18 areas.

19 A. Threshold setting. That's
20 probably the big one.

21 Q. Okay. And what others?

22 A. I'd start with that one.

23 Q. Okay. And then what would I read
24 next if I was really curious?

1 A. I'm not sure. Whichever one you
2 wanted to.

3 Q. Is there one on customer segments?

4 A. As far as?

5 Q. I'm just -- you said this was in
6 multiple guidances. So I'm just trying to
7 figure out what other areas it would be in.

8 A. I'm not sure I follow the question
9 about customer segments.

10 Q. I'm just asking what other
11 guidances you have that lay out this process.

12 A. The working guidelines would be --
13 yeah.

14 Q. Okay. Are they organized by
15 subject area?

16 A. Yes.

17 Q. And what are the subjects beyond
18 thresholds?

19 A. I don't have all them in front of
20 me.

21 Q. Just name of the ones that come to
22 mind.

23 A. LV TAC.

24 Q. Okay. Anything else?

1 A. No.

2 Q. There was a period presumably when
3 Cardinal applied thresholds to all of its
4 customers presumably before your time in the
5 position; is that correct?

6 A. Yes.

7 Q. And when you were setting
8 thresholds initially, you looked at some
9 baseline data, right, to look at what was
10 average or normal --

11 A. Yes.

12 Q. -- correct?

13 And do you know what year was used
14 as that baseline?

15 A. For the initial process, no. As
16 far as when I was involved, that's where we
17 consulted with Linden who had just come from the
18 DEA.

19 Q. Okay. So that would have been in
20 2012?

21 A. That's when I got there. Linden
22 came before I did though.

23 Q. Okay. All right. And was there
24 ever a time -- and so now when you're bringing

1 on a customer, you use 2018 data for what's
2 average or normal, correct?

3 A. Yes.

4 Q. Okay. And is there a point by
5 which thresholds are reset to reflect the fact
6 that prescribing has gone down, for instance?

7 A. Yes.

8 Q. How does that happen?

9 A. We are purchasing refreshed data
10 annually and comparing what the volumes look
11 like and looking how our customer distributions
12 compare to the rest of the market, and then make
13 any adjustments accordingly.

14 Q. Okay. And which data source is
15 this?

16 A. IMS, Symphony Health.

17 Q. Okay. So if from -- and so when
18 you said comparing it to the market, explain
19 what that means.

20 A. The national data. So when we
21 purchase the Symphony data, for example, it's
22 for the majority of the retail market, not just
23 the Cardinal customers.

24 Q. And so if you know that you are

1 40 percent or 20 percent of the market --

2 A. Yes.

3 Q. -- you will say, "So for our
4 customers, if overall sales is 100 million and
5 ours should be 20 million"?

6 A. It would depend on what our --
7 each individual customer looked like. Again,
8 back to that context around size for the total
9 control and total non-control prescriptions, you
10 could have larger customers. You could have
11 smaller customers in the market.

12 Q. So instead of me trying to put
13 words into your mouth, which never works well,
14 tell me, so you get this Symphony and IMS
15 dataset.

16 A. Yes.

17 Q. You look at it.

18 A. Yes.

19 Q. How does that translate into what
20 you do in adjusting or setting thresholds?

21 A. We go through and try to
22 understand what those variational changes, if
23 any, look like and apply that then to the
24 threshold setting methodology.

1 Q. So if you found in 2014 when
2 hydrocodone was rescheduled that sales of
3 hydrocodone -- or prescriptions of hydrocodone
4 or sales went down 30 percent, what would you
5 do?

6 A. We would potentially reduce the
7 hydrocodone thresholds.

8 Q. Is that what happened?

9 A. The 30 percent example?

10 Q. Yeah. I mean, did you go through
11 after the rescheduling and reset hydrocodone
12 schedules -- hydrocodone thresholds?

13 A. Where appropriate, yes.

14 Q. And what is that? So some
15 customers and not others?

16 A. To the customers that it was
17 applicable to make changes, we made changes.

18 Q. And was that the majority of your
19 customers or --

20 A. I don't know. I'm not sure.

21 Q. And how did you decide which
22 customers needed to be changed and which ones
23 didn't?

24 A. Same contextual evaluation.

1 Q. Customer by customer?

2 A. Yes.

3 Q. Are overall threshold levels at
4 Cardinal now higher or lower than what they were
5 when you started in your position? And I'm just
6 talking about opioids in this question.

7 A. Lower.

8 Q. By how much?

9 A. I'm not sure. 40,000 customers.

10 Q. Do you all ever add up -- so you
11 have 200 customers in Montana -- is that about
12 right? Do you ever add up all of the thresholds
13 you have in Montana and figure out what supply
14 of opioids your customers there can purchase?

15 A. Ask me that again.

16 Q. Do you ever for the State of
17 Montana or any state take all of your customers,
18 look at the opioid thresholds, add them all up,
19 and check and see what the number looks like?

20 A. We do what you just described at
21 the individual customer level.

22 Q. And do you ever aggregate that?

23 A. Yes.

24 Q. And what happens? In what context

1 is that done?

2 A. We look at the gaps, the buffer
3 that would exist on what the volume is versus
4 the threshold to make sure we maintain the
5 proper gap between the threshold and the usage.

6 Q. Meaning if a pharmacy customer was
7 buying at 20,000 oxycodone a month and the
8 threshold was 21,000, you might look and say,
9 "Well, we've not left enough of a margin there"?

10 A. Or if that customer went, for
11 whatever reason, from 20,000 down to 5,000, we
12 would lower that threshold.

13 Q. Okay. Do you know how -- do you
14 ever get a report on threshold adjustments
15 across the customer base?

16 A. We look at the number of threshold
17 changes that we make, yes.

18 Q. Is that a report that Cardinal
19 runs or that you run?

20 A. I'm hesitating because it's not
21 like an officially tagged report name or
22 something, but we do monitor the number of
23 changes that are made.

24 Q. And in what context or group or

1 fashion do you do that?

2 A. As far as?

3 Q. Like, is that a -- is that an

4 evaluation meeting you do once a month? Is it a

5 report one of your direct reports gives to you?

6 A. It's part of a metrics that we run

7 to keep tabs on the program.

8 Q. And how often do you do that?

9 A. Once a quarter.

10 Q. And who's involved in that process

11 of reviewing your metrics?

12 A. A lot of people.

13 Q. Are they all people who report to

14 you within your group?

15 A. Inside and outside my group.

16 Q. And is there anybody more senior

17 to you who's involved in that?

18 A. Yes. I think it goes up the

19 chain.

20 Q. To whom?

21 A. I'm not sure exactly who all gets

22 it. It gets filtered through legal.

23 Q. And there's an actual report that

24 you generate?

1 A. That's why I hesitated before and
2 said it's not -- I wouldn't call it a report.
3 It's analytics that we constantly run to
4 determine the question you asked me. Now, the
5 output of it would be numbers that would go into
6 a metric.

7 Q. Okay. And when you say you run it
8 up the chain, what are you running?

9 A. So -- I'm sorry. You lost me.

10 Q. So you say it goes up the chain.

11 A. Yes.

12 Q. What is the "it"?

13 A. Metrics.

14 Q. Yes. In what form?

15 A. Numbers.

16 Q. All right. But there has to be --
17 is there an e-mail that you send? Is there a
18 report you do?

19 A. No. It's metrics on a page.

20 Q. Okay. Does it have a title?

21 A. I'm not sure -- again, it's a
22 culmination of a bunch of different pieces. So
23 I don't know that there's a specific name for
24 the overall chunk of the metrics. I call it our

1 metrics.

2 Q. And so if I was to e-mail Jen
3 after this deposition and say, "Can you find
4 those reports that Todd Cameron was talking
5 about," what would I say to her so that you'd
6 know what to look for?

7 MS. WICHT: Hypothetically.

8 A. I would -- again, Linden gets all
9 of them. I would start with Linden is what I
10 would do.

11 Q. Okay. So just the reports you
12 send to Linden Barber?

13 A. They're not reports. They're
14 metrics.

15 Q. Okay. Whatever you had over
16 lunch ...

17 Okay. So we got to this from the
18 question of whether you ever add up
19 thresholds --

20 A. Yes.

21 Q. -- in a particular jurisdiction.

22 And is that one of the metrics
23 that goes in the metrics that you send to Linden
24 Barber and others?

1 A. So I did not say we add up over a
2 jurisdiction.

3 Q. Okay. So what -- when you said --

4 A. At the customer level.

5 Q. So explain to me the distinction
6 you're drawing.

7 A. Well, you're saying
8 "jurisdiction." What do you mean when you say
9 "jurisdiction"?

10 Q. I mean the State of Montana.

11 A. So, no, we would not do it for
12 just the customers in Montana. We would do it
13 for every customer.

14 Q. Meaning every large customer,
15 every --

16 A. Every customer.

17 Q. Okay. So that means you're
18 running -- whenever you run this report that's
19 not a report --

20 A. Yes.

21 Q. -- you are saying, "We distributed
22 this volume of opioids" or "Our thresholds
23 permitted the distribution of this volume of
24 opioids." Is that correct?

1 A. We constantly review what the
2 threshold is versus what the volume is being
3 distributed to the customer.

4 Q. Across all your customers?

5 A. Yes.

6 Q. So you will be looking when you do
7 this "Our thresholds permit us to supply a
8 billion opioids." You know, "Our actual sales
9 are at 750 million, so we've got 250 million
10 that may be unnecessary gap."

11 A. At the individual customer level,
12 yes.

13 Q. Tell me the distinction you're
14 drawing there.

15 A. That we're looking at what each
16 customer's threshold is versus what the demand
17 is and ensuring that that threshold is set
18 properly.

19 Q. So what is it that you're adding
20 up?

21 A. Those thresholds. But it's not
22 being done to determine what the aggregate, the
23 way you're phrasing an opportunity is. It's
24 being done at the customer level to ensure the

1 customer thresholds are set properly.

2 Q. Okay. All right. So to go back
3 to the question that was originally on the
4 table, there's no place where you're saying the
5 thresholds or sales for all customers in Montana
6 add up to this?

7 A. In the exact way that you just
8 described it, no.

9 Q. Okay. And when you're parsing
10 that, it's because you're doing it at a customer
11 level but not as a jurisdictional or geographic
12 level?

13 A. Yes.

14 Q. And that's the difference between
15 what I'm asking and what you're answering?

16 A. Yes.

17 Q. In thinking about setting up a
18 system to prevent the diversion of opioids, like
19 to maintain effective controls, how far does a
20 threshold-based system get you? How much
21 diversion will that let you identify? Is it
22 80 percent of the total you'll pick up on
23 thresholds, or is that a smaller piece?

24 A. I'm unsure.

1 Q. What I'm trying to get at is, how
2 much of your compliance program is solved by
3 thresholds? Does it -- you know, we can ask --

4 A. I'd have no way of putting a
5 percentage on it.

6 Q. Okay. Your suspicious order
7 reports, how many of those are identified
8 through threshold exceedances?

9 A. If I understood your question,
10 every single one of them.

11 Q. So how many of them come from --
12 how many suspicious order reports come from one
13 of the questions you get from a sales rep or a
14 tip that a sales rep calls in?

15 A. All of the suspicious order
16 reports are because an order hit a threshold
17 that we did not have cause to release, and then
18 we canceled and reported the order.

19 Q. Okay. And so those are the
20 suspicious order reports that you submit to
21 DEA --

22 A. Yes.

23 Q. -- as they exceed threshold?

24 A. Yes.

1 Q. And so what do you call it when
2 Mallinckrodt sends you the letter and you
3 terminate a customer? That's not a suspicious
4 order report?

5 A. No.

6 Q. What is it when a sales rep
7 submits, you know, a tip that they went to a
8 customer and saw a long line around the block,
9 you know, whatever?

10 A. Yeah, we would investigate that
11 pharmacy. There wouldn't be a specific order
12 that would be associated with that tip as you
13 called it.

14 Q. And so when you determine that a
15 pharmacy is suspicious, then your decision is
16 sell controlleds or not sell controlleds?

17 A. Yes.

18 Q. And if you decide not to sell
19 controlleds, do you make a notification to
20 somebody?

21 A. Depends on where the customer is
22 located.

23 Q. Okay. Are you always going to
24 notify the DEA?

1 A. No.

2 Q. When wouldn't you notify the DEA?

3 A. There are certain field offices
4 that have asked to be notified. And there are
5 certain states or BOPs that have been asked to
6 be notified.

7 Q. And do you know if Denver and
8 Seattle are field offices that asked to be
9 notified of terminated customers?

10 A. I do not believe so.

11 Q. And is the Montana Board of
12 Pharmacy one of the boards of pharmacy that you
13 notified?

14 A. I do not believe so.

15 Q. I take it sometimes when you have
16 a suspicious order, you don't terminate the
17 customer, right? You just hold or delete that
18 order or cut the order. And sometimes you do
19 decide it's a broader problem -- and I'm sorry.
20 You're nodding. So yes?

21 A. Yes.

22 Q. And then you would terminate the
23 customer potentially?

24 A. So you said about five things in

1 that string. I was nodding because I was simply
2 trying to follow the question. So what was the
3 specific question?

4 Q. And now I don't even remember what
5 the specific question was.

6 So sometimes a suspicious order is
7 just a suspicious order? You notify the DEA of
8 the suspicious order, correct?

9 A. Yes.

10 Q. But the customer may remain a
11 customer in good standing to whom you continue
12 to supply controlled substances?

13 A. Yes.

14 Q. In some instances when you're
15 investigating the threshold exceedance, you may
16 decide that the customer itself is potentially
17 engaged in diversion?

18 A. Yes.

19 Q. In which case if it was a DEA
20 field office that wanted to know, you would tell
21 them, or a Board of Pharmacy?

22 A. Yes.

23 Q. Okay. How many customers did
24 Cardinal terminate last year?

1 A. I don't know the exact number.

2 For the last 12 months, hundreds.

3 Q. Hundreds?

4 A. Yeah.

5 Q. And how many of those started with
6 a suspicious order?

7 A. Probably very few.

8 Q. So very few were started by an
9 order that exceeded a threshold?

10 A. As far as the termination, yes.

11 Q. And so where did the majority of
12 them start from?

13 A. Where the majority of what
14 started? The termination?

15 Q. The terminated customers.

16 A. The customers most commonly are
17 terminated based off of the numbers, the review,
18 the contextual size, how much is controlled,
19 which specific controlled substances, potential
20 growth in a controlled substance, the mixes
21 within the controlled substance that we talked
22 about earlier.

23 Q. And so how are -- in what context,
24 like how is Cardinal scanning the data to

1 identify those pharmacies? Is that something
2 that you're doing at, you know, a monthly
3 review, or what's the process there?

4 A. Oh, we've got a scoring system
5 that evaluates all of the objective criteria
6 components. And we use that scoring system to
7 segment the customers along with volume.

8 Q. And to identify the customers'
9 scores, is somebody triggering again a report
10 or --

11 A. Yeah. The score is viewed in a
12 bunch of different ways.

13 Q. And what is the trigger that would
14 identify to the employees in your unit which
15 customers had a problematic score?

16 A. The volume, and then the specific
17 mixes of controlled substances.

18 Q. So that's what constitutes the
19 grounds for suspicion?

20 A. Yes.

21 Q. I'm just wanting a procedural
22 mechanism that causes you to know who that is.

23 A. You lost me. I'm sorry.

24 Q. Are you guys running daily

1 reports?

2 A. Oh, I see. Yes. And we're
3 reviewing each individual customer for that
4 purpose, as well as when a threshold event
5 occurs.

6 Q. Okay. And is there a daily -- is
7 there a report that is produced again or --

8 A. Again, I wouldn't call it a
9 specific report. The analytics team is looking
10 at it. The investigative team is looking at it.
11 I'm looking at it. The legal team is looking at
12 it. I made reference to LV TAC earlier. Those
13 are factors that determine what customers go in
14 front of LV TAC.

15 Q. Right. And there's something that
16 pulls them out of the data so that you know to
17 look at them. And I'm just wondering what's
18 that interface?

19 A. As far as like a system? Again,
20 the data exists in multiple systems. So it
21 would depend on what area you were in that would
22 determine what you were looking at.

23 Q. Okay. So if you were coming in
24 after this meeting and said, "I want to see

1 every customer who scored over" -- what would be
2 a score that would --

3 A. Well, it would depend. It would
4 depend.

5 Q. So, again, how often and through
6 what vehicle are you all looking at this to
7 identify which customers need the deeper
8 contextual investigation?

9 A. The easiest one is the threshold
10 event mechanism. Each time there's an event,
11 the customer goes through the review process.

12 Q. Okay. But that's actually a small
13 percentage of your terminations?

14 A. It's a small percentage of the
15 terminations, not a small percentage of the
16 customers.

17 Q. Okay. And so for those other
18 terminations, again, what lifted up those
19 customers for you to know to look at them?

20 A. It could have been a threshold
21 event that caused us to go in and do a visit.
22 Again, what I talked about earlier was how we
23 set the thresholds, and we look at the
24 contextual size of the customer. And the way we

1 set the thresholds prevents the volume from us
2 from becoming indicative of diversion.

3 So I would tell you the customers
4 we cut off in the last year to your point have
5 all been cut off because of volume outside of us
6 in the total dispensing the customer, not
7 purchases from us.

8 Q. So meaning from all of those other
9 data sources?

10 A. No, from the customer themselves
11 on what they're dispensing.

12 Q. The data feed that you get from
13 the customer?

14 A. No. We go do a visit.

15 Q. Okay. And so how do you see what
16 they're dispensing volume is outside of
17 Cardinal? How is that evident?

18 A. That's when we have them run the
19 dispense reports when we do the visit that we
20 talked about earlier.

21 Q. Got it. Okay. So just to make
22 sure I'm understanding, what you're saying is of
23 that pool of hundreds of customers you
24 terminated last year --

1 A. Yes.

2 Q. -- a small number of them were
3 done on the basis of a threshold exceedance.
4 But a threshold exceedance might cause you to do
5 a site visit. And during the site visit, you'd
6 ask for their dispensing data. That would be
7 problematic. And with other factors, you would
8 terminate that customer?

9 A. Yes.

10 Q. Okay.

11 A. Yes.

12 Q. We're communicating better.

13 A. Yes.

14 Q. And when you first started in your
15 position, was the number of customer
16 terminations higher or lower than what it is
17 right now?

18 A. Higher.

19 Q. By roughly what measure? I mean,
20 double --

21 A. I wouldn't know what factor to put
22 on to it.

23 Q. In most of your terminations, what
24 types of customers are they?

1 A. Retail independents.

2 MS. WICHT: Can we take a restroom
3 break when you're at an okay stopping
4 point?

5 MS. SINGER: Yes. You know what?
6 Why don't we go ahead and do it now.

7 (Recess taken.)

8 BY MS. SINGER:

9 Q. So, Mr. Cameron, you have Exhibit
10 5.

11 A. Yes.

12 MS. SINGER: Did we give it to
13 you, Jen?

14 MS. WICHT: I don't think so.

15 THE WITNESS: It's not the same as
16 3, right?

17 MS. DEYNEKA: I think it is.

18 MS. SINGER: Oh, I'm sorry.

19 BY MS. SINGER:

20 Q. So Exhibit 3, "Process to
21 Establish Suspicious Order Monitoring Threshold
22 Limits." Do you have that in front of you,
23 Mr. Cameron?

24 A. Yes.

1 Q. So when you set thresholds, it was
2 set for specific customers and for classes of
3 customers, correct?

4 A. It is set for each specific
5 customer.

6 Q. Okay. And one of the factors you
7 look at is the customer segment a customer
8 belongs to, whether they're a chain or an
9 independent retail pharmacy?

10 A. That is a factor.

11 Q. Okay.

12 A. When I made reference to segment
13 earlier when we were talking, I was probably
14 talking about the segment of kind of the bell
15 curve again, but we do look at the class of
16 trade of the customer.

17 Q. Okay. And then -- all right.

18 Let's move to page 3, which is
19 Bates number 1169.

20 A. Yes.

21 Q. So at VI, it talks about
22 multiplying the monthly quantity of base code by
23 a factor --

24 A. Yes.

1 Q. -- of 3, 5, or 8.

2 A. Yes.

3 Q. Can you explain where those
4 factors come from and what their significance
5 is?

6 A. I cannot. I've never seen this
7 before. Again, I don't know if that is the
8 DEA's algorithm that we talked about earlier or
9 not.

10 Q. Is that something that Cardinal
11 uses now?

12 A. No.

13 Q. Have they ever used it during your
14 tenure on the compliance side?

15 A. No.

16 MS. WICHT: The algorithm you're
17 asking about, right?

18 MS. SINGER: I'm asking about this
19 multiplication by a factor of 3, 5, or
20 8.

21 THE WITNESS: Correct.

22 MS. WICHT: Maybe that's what you
23 were answering as to. Sorry. I didn't
24 mean to confuse -- okay.

1 A. Yeah. I've never seen the 3, 5,
2 or 8 before.

3 Q. Okay. And then going to the first
4 page, 1167 Bates number. Under 4.0 Policy, the
5 second and third lines have the sentence, "The
6 baseline purchase pattern is then adjusted up by
7 a statistically significant factor or variable
8 to formulate the threshold limit."

9 Have I read that correctly?

10 A. Yes.

11 Q. And is that a concept that
12 Cardinal still applies?

13 A. No.

14 Q. Okay. So when you look at the
15 baseline level of what's normal or average --

16 A. Yes.

17 Q. -- do you gross that up by any
18 factor in setting a customer's threshold?

19 A. No. It would depend on the
20 specific individual customer, the context of all
21 the objective pieces of the customer, and the
22 volume needed of that customer.

23 Q. Okay. So meaning you might,
24 depending on the customer, or you might not?

1 A. I'm sorry. Ask me the question
2 again.

3 Q. So you said whether you adjust for
4 some margin depends on the specific factors of
5 the customer.

6 A. Yes.

7 Q. So you do it sometimes and not
8 others?

9 A. Yes. I don't -- not in reference
10 to whatever that verbiage is that's written
11 here.

12 Q. Okay. So do you build in any
13 buffer to a threshold above the customer's
14 typical use?

15 A. Yes.

16 Q. And is there a set factor for
17 that?

18 A. There is not.

19 Q. Okay.

20 A. It's going to vary by the volume,
21 the drug, and all the contextual factors for
22 that specific customer.

23 Q. Okay. So how big that buffer is
24 will vary, but the fact of the buffer is a

1 constant?

2 A. Yes. Can I correct that? So when
3 you say "a constant," not every customer gets a
4 buffer.

5 Q. Okay.

6 A. Again, it will be individual
7 customer based, and you could have customers
8 that might be at the threshold limit, and that's
9 what they're to get.

10 Q. Okay. And what would make you
11 decide -- how do you decide whether a customer
12 gets a buffer or not?

13 A. We determine what the volume is
14 they need versus what we think an acceptable
15 normal range for that customer size and all the
16 contextual factors would be.

17 Q. And so when you're doing this
18 review of each customer as they come in and all
19 the time, that's one of the judgments you're
20 making?

21 A. Yes.

22 Q. And do most of your customers have
23 buffers?

24 A. Yes.

1 Q. And is there a typical buffer
2 level?

3 A. No.

4 Q. Is there an average?

5 A. There probably is. I have no idea
6 what it is.

7 - - -

8 (Montana-Cardinal Exhibit 5 marked.)

9 - - -

10 Q. All right. So now actual Exhibit
11 5. All right. Mr. Cameron, you should be
12 looking at CAH_MDL2804_220583. That's the Bates
13 number at the bottom.

14 A. Yes, yes.

15 Q. All right.

16 MS. WICHT: I think, Linda -- I'm
17 not going to cut off questioning on this
18 document. I guess -- I think this is
19 obviously something that was produced in
20 the MDL. As I understand the MDL
21 protective order, I'm not sure it would
22 allow --

23 MS. SINGER: So Montana AG has
24 signed that protective order.

1 MS. WICHT: The MDL protective
2 order?

3 MS. SINGER: Yep.

4 MS. WICHT: Okay. Thank you for
5 that information. And as I said, I will
6 let him answer questions on it, and
7 maybe that resolves it. I'll think
8 about it. But thank you.

9 MS. SINGER: Of course.

10 BY MS. SINGER:

11 Q. All right. So do you recognize
12 this as an e-mail to you?

13 A. From me?

14 Q. Oh, from you. Yes.

15 A. Yes.

16 Q. All right. And the subject reads
17 what?

18 A. "Forward: 12 percent Buffer
19 Customer List."

20 Q. Okay. And this e-mail is from
21 2014, yes?

22 A. Yes.

23 Q. And so according to this e-mail,
24 there is a group of thresholds, thresholds

1 ending in 3 that have a 12 percent buffer --

2 A. Yes, sir.

3 Q. -- across the board. Is that
4 correct?

5 A. It wouldn't be across the board,
6 no.

7 Q. Okay. So it says here, "Some
8 thresholds now ending in 3, these have had a
9 buffer of 12 percent applied to them."

10 A. Yes.

11 Q. Okay. So tell me what in this
12 e-mail or your recollection makes you believe
13 that it was some customers and not others that
14 fit in the threshold ending in 3?

15 A. The bottom e-mail.

16 Q. Okay. Read that.

17 A. Do you want me to read the whole
18 thing?

19 Q. Just the part that --

20 A. So it's looking at two or more
21 threshold events in oxycodone or hydrocodone in
22 the last six months. Had to be within three
23 days or left within the accrual cycle. And then
24 it excluded secondary account thresholds, retail

1 independents, and had to be under 30,000

2 oxycodone or hydrocodone, and could not have a
3 threshold that ended in 9 or 5.

4 Q. And what does the ending number of
5 a threshold tell you about a customer?

6 A. It tells you the steps that were
7 taken from a review standpoint to set the
8 threshold.

9 Q. Okay. Meaning so something that
10 ends in a 9? What has happened with that
11 customer?

12 A. It's been set by LV TAC.

13 Q. Okay. And a threshold ending in
14 5?

15 A. There's been some factors that
16 somebody has set that threshold and doesn't want
17 anybody to change the threshold.

18 Q. So it's locked in?

19 A. Yes.

20 Q. And do you have a glossary that
21 explains what all of these different threshold
22 digit means?

23 A. I believe there is, yes.

24 Q. Okay. So for this -- the group of

1 customers who met these criteria --

2 A. Yes.

3 Q. -- a 12 percent buffer applied?

4 A. Yes.

5 Q. Okay. And these were -- so

6 accrual cycle --

7 A. Yes.

8 Q. What is that?

9 A. That is the window of days in
10 which the threshold is accumulated. So, for
11 example, the month.

12 Q. Okay. And for Cardinal, that's a
13 30-day period?

14 A. For the monthly threshold, yes.

15 Q. Okay. And is that -- you
16 mentioned before that you have staggered dates
17 so they don't all come up at once?

18 A. Exactly.

19 Q. So it's 30 days from that date to
20 the next month every time?

21 A. Yeah.

22 Q. It's not a rolling threshold?

23 A. No. It resets on a specific date.

24 Q. Okay. All right. So for

1 customers who'd had two or more exceedances for
2 hydrocodone or oxycodone --

3 A. Yes.

4 Q. -- in the last six months?

5 A. Yes.

6 Q. And they're clearly customers who
7 are running up against their threshold at the
8 end of the month.

9 A. Yes.

10 Q. Not secondary accounts. What's a
11 secondary account?

12 A. Back to the concept of ensuring
13 that the orders we distribute make sense for the
14 context of the volume that's coming to us for
15 the customer. It's somebody who we would not
16 consider primary or buying the majority of their
17 non-controls and controls from us. So they're
18 buying --

19 Q. From somebody else?

20 A. From somebody else.

21 Q. Okay. So for all of these
22 customers, this is basically -- these are
23 customers who are exceeding threshold at the end
24 of the month, you're giving them a 12 percent

1 buffer?

2 A. Yes.

3 Q. Okay. All right. So to your
4 point about contextualizing earlier, there are
5 also rules and classes that you apply for
6 certain kinds of customers?

7 A. Yes.

8 Q. How do you identify an improper
9 Internet seller?

10 A. Any customer that we see that is
11 soliciting prescriptions over the Internet
12 without having the proper corresponding
13 responsibility interface with the patient and
14 the proximity to the doctor.

15 Q. So they don't have a physical
16 location in the place where they're dispensing
17 prescriptions, right? You're filling a
18 prescription in Kansas City, but you don't have
19 a pharmacy location there?

20 A. Filling for a patient in Kansas
21 City, yes.

22 Q. Okay.

23 A. Yes.

24 Q. And so how do you identify those

1 pharmacies?

2 A. You can see it on -- you would see
3 it on their website.

4 Q. And so who is scanning websites to
5 find these?

6 A. We do when we vet the customers,
7 when we visit them and turn them on.

8 Q. Okay. And then one other question
9 on the document that's Exhibit 3 again at Bates
10 numbers 1169 through 70. Cardinal is giving
11 credit -- and this is 4.2.4a, very bottom,
12 carrying over to the next page.

13 A. Yes.

14 Q. -- for customers who have a loss
15 prevention program.

16 Is that something that Cardinal
17 still does?

18 A. I'm sorry. 1169?

19 Q. Yes.

20 A. And then I'm reading 4.2.4a?

21 Q. Yes.

22 A. Okay. And this is "i" I should be
23 reading?

24 Q. Yep.

1 A. No, this is not something we do.

2 Q. Have you ever applied that policy

3 during your tenure in compliance, that you give

4 credit for having a loss prevention program?

5 A. It could have been in place when I

6 first arrived. I don't remember it being the

7 case, but I know it's not part of how we set

8 thresholds today.

9 Q. Did you proactively abolish that?

10 Was that something that you got rid of that you

11 recall?

12 A. I do not recall that.

13 Q. Okay. Does it strike you as a

14 good policy?

15 A. I don't think I've ever heard that

16 before, so I don't really -- I'm not really sure

17 about it.

18 Q. Well, just looking at it now.

19 A. Yeah.

20 Q. Is this something you think makes

21 sense in an anti-diversion program?

22 A. Again, we're looking at the

23 contextual size and factors of the customer to

24 set the thresholds appropriately based on each

1 individual customer. That's not an objective
2 component that we would use.

3 Q. Okay. So no?

4 A. Ask me again.

5 Q. That's not a factor that you would
6 use in setting a customer's threshold?

7 A. It is not a factor I use today.

8 Q. That's not a factor you do use?

9 A. Yes.

10 Q. Do you think it makes sense?

11 A. I don't know enough about what the
12 impetus was for it on how they were trying to
13 use it exactly. So it's not fair for me to say
14 it makes sense or not. I don't understand
15 enough about what the concept would really be,
16 how you do that.

17 Q. Okay. All right. It's not
18 something that you would go back to your office
19 this afternoon and think you ought to put back
20 in place?

21 A. No.

22 Q. All right. Next is Number 6.

23 Okay. We're going to come back to that.

24 Do you know when Cardinal first

1 reported a suspicious order in the State of
2 Montana, a suspicious order arising in the State
3 of Montana?

4 A. I do not know.

5 Q. Does 2013 sound right to you?

6 A. I do not know.

7 Q. Okay. I want to go back for a
8 second using your prerogative that you've used.

9 When we were talking about
10 terminated customers --

11 A. Yes.

12 Q. -- you said most of them weren't
13 terminated as a result of exceeding threshold?

14 A. Yes.

15 Q. And I just want to make sure I
16 understand that. Is what you're saying they
17 were terminated for reasons other than exceeding
18 threshold?

19 A. Yes.

20 Q. But it was a threshold exceedance
21 that first triggered your scrutiny of the
22 customer?

23 A. Could have been.

24 Q. But you don't know?

1 A. I mean, some cases, it would have
2 been, and some cases -- I mean, we have
3 terminated customers that have never hit a
4 threshold. It just depends on the customer, our
5 distribution percentage, what that customer
6 looks like.

7 Q. How many customers who hit
8 threshold are terminated? What proportion?

9 A. I don't know the exact number, but
10 it would be a small percentage.

11 Q. And is an order that exceeds a
12 threshold a suspicious order?

13 A. By definition, yes.

14 Q. It is an order that meets the CSA
15 and regulatory guidance for a suspicious order?

16 A. Yes.

17 Q. And do you think it actually
18 signals diversion?

19 A. Not in every case.

20 Q. In most cases?

21 A. It would depend on the customer,
22 but the majority of our suspicious orders, we do
23 not believe that that customer is engaged in
24 diversion.

1 Q. Are you aware when Cardinal put in
2 place its threshold system, there were a number
3 of customers that were kind of newly identified,
4 and Cardinal went through and sorted out who was
5 suspicious and who wasn't. Is that an event
6 that you're familiar with generally?

7 A. The concept makes sense to me.

8 Q. Okay. Do you know how many of
9 those customers that were identified through
10 that process were subsequently terminated?

11 A. I do not. I know there were
12 terminations prior to my arrival.

13 Q. Okay. And is there a process -- I
14 mean, we talked painfully about those metrics
15 that go up the chain.

16 Is there any kind of audit that
17 Cardinal does of your own thresholds, whether
18 they are appropriately tuned to identify
19 suspicious orders? And are you going back and
20 doing the analysis of those to see if they
21 actually are pointing to suspicious orders of
22 customers?

23 A. Again, by definition, every order
24 that hits our threshold that does not meet our

1 criteria is a suspicious order, which is why we
2 do not fill it and report it.

3 Q. Okay. And as you're thinking
4 about this from an anti-diversion perspective --

5 A. Yes.

6 Q. -- are threshold exceedances
7 actually pointing you to customers who you
8 believe are engaged in diversion?

9 A. It would depend on the customer.
10 But, again, kind of back to my meeting with DEA,
11 based on how we set thresholds and our position
12 in the supply chain with that specific customer
13 will determine what volume of controlled
14 substances we are comfortable supplying to that
15 customer.

16 Many times that volume is well
17 below the volume the customer needs. And the
18 total volume makes sense for the contextual size
19 of the customer. But because we're only getting
20 a smaller portion, we're going to ensure that
21 that smaller portion makes sense analytically,
22 which leads to a lot of suspicious orders.

23 Q. That aren't actually signs of
24 diversion?

1 A. Yes.

2 Q. In December 2007 -- I know this
3 was before your time.

4 A. Yes.

5 Q. So if you're familiar with it.
6 Cardinal sent a letter to Linden Barber when he
7 was at DEA and said based on these new
8 thresholds, that you had terminated certain
9 customers with AHOP drugs, which you will know
10 what it stands for, right?

11 A. I do know what AHOP stands for.

12 Q. Okay. Which is what?

13 A. Alprazolam, hydrocodone,
14 oxycodone, and phentermine.

15 Q. That wasn't a test. I couldn't do
16 it.

17 A. That's what it is.

18 Q. Greater than 30 percent of total
19 purchases?

20 A. Right.

21 Q. So all of these customers --

22 A. So pulling the AHOP out threw me
23 off. This is a letter from who to who?

24 Q. From Cardinal to Linden Barber,

1 and said, "There are a bunch of customers from
2 our new thresholds that" --

3 A. I'm sorry. This is dated when?

4 Q. December 2007.

5 A. Okay. Got it. Sorry.

6 Q. That's okay. You're good at the
7 questioning.

8 That based on these thresholds,
9 these customers were buying -- that more than
10 30 percent of their purchases were for AHOP
11 drugs --

12 A. Okay.

13 Q. -- and that you were terminating
14 them.

15 A. Okay.

16 Q. Do you know anything about these
17 customers?

18 A. I do not.

19 Q. Okay. Has the percentage of
20 orders that are being flagged as suspicious
21 changed over time? This may be implicit in your
22 conversation with DEA. But when you started in
23 your role in compliance, what percentage of your
24 opioid orders were flagged as suspicious?

1 A. I don't know the specific
2 percentage of the orders that would have been
3 flagged.

4 Q. Okay. Do you know what it is now?

5 A. Not as a percentage of the total
6 orders, no.

7 Q. So in what form do you know those
8 numbers?

9 A. I don't -- again, because each
10 threshold is set at the individual customer
11 level, I don't have an overarching X percent of
12 orders are held.

13 Q. Okay. So that's not one of the
14 metrics you look at?

15 A. It is not.

16 Q. Do you report suspicious orders
17 for reasons other than threshold exceedances?

18 A. No.

19 Q. When you terminate a customer,
20 have you ever done, for lack of a better word,
21 an autopsy on the customer to figure out when
22 you might have known that this was a customer
23 engaged in diversion or potentially engaged in
24 diversion?

1 A. Yes.

2 Q. Do you do that as a matter of
3 course?

4 A. Yes.

5 Q. And what have you learned in that
6 process?

7 A. We learned that the objective
8 components we used to evaluate customers are
9 appropriate.

10 Q. And how can you tell that?

11 A. Because the factors that cause a
12 customer to get reviewed usually come up prior
13 to the point in time in which we'd make a
14 determination to cut somebody off. Oftentimes
15 it's growth that causes us to cut somebody off
16 and specific controls or specific strengths
17 within a control.

18 Q. And is there a growth level that
19 tends to be highly indicative of diversion?

20 A. There's not, because it really
21 depends on each individual customer that -- a
22 volume that might be indicative of diversion for
23 one customer is not at all for another customer
24 because that overall contextual size of each

1 customer.

2 Q. So you haven't seen that while a
3 2 percent growth might be a signal in some
4 cases, 10 percent is always?

5 A. No.

6 Q. Okay.

7 A. No. It really does vary by
8 customer.

9 Q. And so when you say it's
10 validated, the criteria you're using, have you
11 seen in those cases you've looked back on that
12 you could have told earlier?

13 A. I don't think so.

14 Q. So when you say that the signs
15 that you're looking at were present, what do you
16 mean by that?

17 A. Well, when I say the signs are
18 present, obviously the factors are present for
19 any customer that's buying controls. It's just
20 a matter of us identifying kind of back to that
21 bell curve concept at which point in time we
22 apply heightened scrutiny based on that mix and
23 where it falls into the segment is usually --
24 it's customers within those areas that are the

1 ones that potentially end up getting cut off.

2 Q. And with one of those factors -- I
3 just want to go back. You talked about this
4 20 percent as an average or normal level for
5 total orders that are controlled as being
6 comfortable.

7 A. Yes. I didn't say orders, because
8 the order number is probably different based on
9 how controls get grouped into an order.

10 Q. So volume?

11 A. But as far as dispensed units or
12 scripts.

13 Q. Okay. Fair enough. So when
14 you're looking at this in analyzing a customer,
15 do you apply some number greater or less than 20
16 when looking at it?

17 A. There's a range for sure, yes.

18 Q. And what's the range that you use?

19 A. I would tell you a normal range
20 for controls is in that [REDACTED] percent, common
21 range I would call it.

22 Q. And is that true across the
23 opioids, so fentanyl same as oxycodone,
24 meaning -- you know what? It was a nonsensical

1 question. I'll withdraw it.

2 And when you're looking at that 15
3 to 25 percent, how are you factoring in the fact
4 that it's maybe higher MMEs or higher dose
5 generally? How does that get weighted in
6 Cardinal's system?

7 A. That's all part of the review
8 factor that -- to your point, it could be
9 25 percent, and your MME could be very, very
10 low. It could be 10 percent, but your MME could
11 be high.

12 Q. And that's something that once the
13 customer has been flagged to you and you're
14 sitting down with the file, that's one of the
15 things you're looking at? It happens at a
16 customer-by-customer level?

17 A. Yes.

18 Q. Has the percentage or range
19 changed over time?

20 A. Yes.

21 Q. And what was it when you started?

22 A. I would say it was probably
23 average was closer to 25 at that point in time.

24 Q. Okay. And, again, we were talking

1 about what's in that 20 percent that matters?

2 A. Yes.

3 Q. What are you looking for there?

4 If it is highly concentrated to oxycodone or
5 hydrocodone, is that a red flag to you?

6 A. Yes.

7 Q. Okay. And are there other things
8 within that that are red flags?

9 A. Yes.

10 Q. What are they?

11 A. The mix within the oxycodone.

12 Q. You mean the dose?

13 A. The strengths that you asked me
14 about earlier. Same thing with hydrocodone.
15 Alprazolam, specific strengths within
16 alprazolam. The benzos, ADD, ADHD drugs, total
17 opioids.

18 Q. Okay. And how do you figure out
19 which drugs are highly diverted?

20 A. Linden Barber.

21 Q. Okay. And how does he figure it
22 out?

23 A. He came from the DEA.

24 Q. So the DEA is telling you, or he's

1 applying methods that he learned at DEA?

2 A. I'm not sure where he learned
3 them. But we've gotten a lot of consult from
4 Linden, yes.

5 Q. Okay. And do you know what data
6 he is looking at to make that judgment?

7 A. I do not.

8 Q. And have the drugs or doses you've
9 been looking at changed over time, too?

10 A. Yes.

11 Q. And in what way?

12 A. They've decreased.

13 Q. Meaning the volume of them has
14 decreased?

15 A. And the ratios.

16 Q. Okay. And have new drugs or drug
17 families or doses become of concern that weren't
18 five years ago?

19 A. Yes.

20 Q. And what are those?

21 A. I don't have a comprehensive list.
22 You know, you mentioned hydrocodone in October
23 of '14. I saw the morphones go up. Tramadol
24 had gone from not a control to a control.

1 Buprenorphine, while it's a treatment drug, has
2 abuse possible. It's becoming more prevalent
3 prescribed to treat opioid addiction, but also
4 has abuse potential. Those are some examples.

5 Q. Now, one of the things in your
6 Know Your Customer criteria -- and I didn't put
7 a document with this. So I will -- I will
8 confess to that, and hopefully it rings a bell.

9 A. It's okay with me.

10 Q. So it's indicates that customers
11 can -- that when you're looking at the
12 percentage of controlled substances, you're
13 looking only at Cardinal's orders as you
14 identified to DEA, recognizing that a customer
15 may be buying from other distributors.

16 A. Yes.

17 Q. So controlleds may be
18 overrepresented in Cardinal's supply?

19 A. Yes.

20 Q. And so a customer can give you
21 their order data --

22 A. Yes.

23 Q. -- and ask you to look at the
24 whole picture?

1 A. Yes.

2 Q. But Cardinal only gives them
3 credit for 50 percent of non-cardinal
4 purchases --

5 A. Yes.

6 Q. -- is that correct?

7 A. Correct.

8 Q. Is that because they're 50 percent
9 less suspicious?

10 A. No.

11 Q. So why is that?

12 A. Because if we gave 100 percent, we
13 would then be allowing customers to buy all of
14 their opioids from us --

15 Q. Okay.

16 A. -- which is obviously a bad thing.

17 Q. And so it seems like the
18 incentives run in two ways, right? You don't
19 want them to just buy their opioids from you,
20 but you'd also like them to buy their
21 non-controlleds from you, too?

22 A. We are focused on ensuring that
23 the orders make sense for the context of the
24 customer for what they're dispensing in totality

1 and what they're buying from us. And that's how
2 we ensure that what we distribute to that
3 customer, that all those orders, control and
4 non-control, make sense.

5 Q. So a customer can avoid hitting
6 their threshold, right? They can avoid being
7 cut off in two ways. They can lower the
8 controlleds they're ordering from you, or they
9 buy more non-controlleds from you. Either one
10 would solve that problem presumably.

11 A. It depends on the customer. If we
12 are not comfortable with their dispensing
13 totality, we cut them off regardless of the
14 volume that comes from us.

15 Q. Understood. But within this
16 universe of just looking at just the single
17 factor, those are the two ways you can rebalance
18 that equation; less controlleds, more
19 non-controlleds, correct?

20 A. If we are comfortable with how the
21 customer looks in totality from a dispensing
22 standpoint, we will then ensure that the volume
23 of controls is proportionally within a normal
24 range of the non-controls.

1 Q. Okay. Meaning in the context of
2 other factors?

3 A. I'm not sure I can say yes to that
4 or not.

5 Q. I think you already did.

6 A. Okay.

7 Q. One of the things that has varied
8 in Cardinal's SOPs over the years is whether you
9 want sales representatives to let a customer
10 know that they're hitting threshold.

11 A. Yes.

12 Q. There used to be a dialogue
13 process, an early dialogue process. Does that
14 ring a bell? No?

15 A. Can you tell me more?

16 Q. Just where sales representatives
17 were encouraged to reach out to customers and
18 say, "Hey, you're close to threshold."

19 A. Yes, yes.

20 Q. Does that still happen?

21 A. Sales is made aware if a
22 customer's accrual of controlled substances in a
23 specific drug family is disproportionate to the
24 threshold versus the time remaining in accrual

1 to understand if something has changed in that
2 customer's business and purchasing patterns.

3 Q. Meaning if it is halfway into the
4 month and they're at two-thirds of the
5 threshold, the sales representative will reach
6 out? And what is the conversation that they
7 have?

8 A. They would talk about what the
9 previous historical purchases look like and what
10 it looks like they are trending towards and
11 trying to understand were you a secondary
12 customer that's becoming primary, did a pharmacy
13 up the street close and you've picked up new
14 patients, trying to understand what's changed
15 that caused that increase in volume.

16 Q. Okay. And so the customer comes
17 back to the sales rep with a legitimate
18 explanation; there's a new clinic that opened
19 nearby, a pharmacy down the street closed. Then
20 what is Cardinal's response to that?

21 A. It depends on what the drug is and
22 the volume of that drug and the context of the
23 customer. It could be to increase the
24 threshold. It could be to not increase the

1 threshold. It could be to do a site visit.

2 Might have to go in front of LV TAC to make the
3 determination.

4 Q. Okay. And what -- in the ordinary
5 course, if the sales rep comes back with a
6 legitimate explanation, is it Cardinal's policy
7 to verify that explanation in every case?

8 A. It depends on the numbers.

9 Q. So that means -- if there's no --
10 if nothing else is ringing a bell for you, then
11 Cardinal's going to say, "Okay." But if there's
12 something else that causes concern that you
13 might ask them to verify, do a site visit,
14 something else?

15 A. Or the specific volume.

16 Q. Okay. Okay.

17 A. So an increase from 2,000 to 3,000
18 probably wouldn't require a lot of extra steps.
19 Going from 30,000 to 50,000 would.

20 Q. Okay. So it's a discretionary or,
21 as you would say, a contextualized call as to
22 whether you're going to verify?

23 A. Yes.

24 Q. How many of your customers give

1 you the data on the orders from other
2 distributors? You could do it as customers or
3 you could do it as volume.

4 A. Tell me exactly what you mean by
5 give us the data.

6 Q. Excuse me?

7 A. Tell me exactly what you mean by
8 give us the data.

9 Q. So you know this idea that if you
10 provide the data on your opioid orders from
11 another distributor or your non-opioid orders,
12 how many of your customers will give you that
13 data?

14 A. And I'm sorry, but tell me what
15 you mean when you say "give us the data."

16 Q. So when we talked about that
17 50 percent credit, that's the data I'm talking
18 about, which will be crystal clear in the
19 record.

20 A. So that 50 percent delta would be
21 driven off of data feed and site visit. It
22 wouldn't be something that would be given to us
23 by the customer that we would put any weight
24 into.

1 Q. That would what?

2 A. That we would put any weight into.

3 We wouldn't use --

4 Q. That if they just printed it out
5 and handed it to you? You're talking about
6 something where they give you electronic access?

7 A. Yes, or we do a visit and capture
8 the information.

9 Q. How would you capture that
10 information on a visit?

11 A. That's when the investigators go
12 in, and they run the aggregate level dispense
13 data.

14 Q. Meaning they go into the pharmacy
15 system themselves?

16 A. Not the investigator, no. The
17 pharmacy does, but the investigator is there
18 when it happens.

19 Q. Okay. The investigator is there
20 with the pharmacy staff who's running that
21 report?

22 A. Yes.

23 Q. Okay. And that's just more
24 reliable than a customer putting it into a

1 survey?

2 A. Yes.

3 Q. Have you observed any trends in
4 the geographic supply of opioids over the five
5 years you've been there in that compliance role;
6 volumes, types of drugs?

7 A. Yes.

8 Q. And what have you observed?

9 A. We've seen prescribing, to some
10 degree, start to come down. We've seen, like we
11 talked earlier, the control percentage mixes
12 within oxycodone, for example, start to come
13 down.

14 Q. And have you seen that in
15 particular parts of the country, or has that
16 been across the board?

17 A. It would depend on how far down
18 your geography goes as to answer that question.

19 Q. Tell me what you mean by that.

20 A. Like, I can't speak to Whitefish.

21 Q. But could you speak to Appalachia,
22 for instance? Is that what you're saying?

23 A. Yeah, not -- probably not as broad
24 as Appalachia but individual states within

1 Appalachia.

2 Q. Okay. And are there any trends
3 you've observed in Montana?

4 A. No.

5 Q. Have you observed any changes in
6 the class of trade -- I think is the term you
7 used -- of customers who are selling opioids or
8 engaged potentially in diversion of opioids?

9 A. I'm sorry. Ask me that again.

10 Q. Have you seen any changes in the
11 class of customer, the trade, who are in the
12 volume that they are selling or whether they are
13 potentially engaged in diversion?

14 A. Meaning?

15 Q. Meaning have you seen that
16 national chains --

17 A. Okay.

18 Q. -- have become more of a problem
19 or rural areas?

20 A. No.

21 Q. Has Cardinal ever lowered
22 thresholds in an area because you observed an
23 oversupply into the area? An oversupply of
24 opioids is what I mean.

1 A. Since I've been in the role?

2 Q. Yes.

3 A. No.

4 Q. And when you asked that question,
5 is that because you know of something before you
6 got involved or because you don't know what
7 happened before you were involved?

8 A. I don't know what happened before
9 I was involved.

10 Q. Okay. So, again, I know your
11 knowledge is really 2012 and later, but having
12 looked back at Cardinal's compliance and
13 anti-diversion program before you started, do
14 you think Cardinal was doing everything it
15 needed to to prevent diversion pre-2012?

16 A. I really have no clue what was or
17 wasn't being done.

18 Q. Okay. So I think his title is
19 chairman, George Barrett.

20 A. Yes.

21 Q. When he testified in Congress last
22 year or this year, whenever it was, he said that
23 Cardinal's compliance system is better now
24 because it's more objective.

1 A. Yes.

2 Q. In what way has Cardinal's
3 compliance system become more objective?

4 A. I think in our ability to use and
5 analyze data to objectively understand the
6 contextual size of the customer.

7 Q. Okay. So, again, to make sure I'm
8 understanding your comment in the context of
9 what you've said today, it sounds to me like
10 what you're saying is that the individualized
11 determinations you're making about customers are
12 more data driven or data informed, although
13 they're still decisions that you all are making
14 about individual customers?

15 A. Yes.

16 Q. Okay. Meaning that it's not a
17 computer that's telling you pharmacy X or
18 pharmacy Y?

19 A. Yes.

20 Q. Okay. What do you think is the
21 strongest feature of Cardinal's current system
22 to prevent diversion?

23 A. The fact that we ensure that our
24 orders of controlled substances makes sense for

1 the contextual size of the customer that we're
2 supplying to.

3 Q. So the thing you warned the DEA
4 about is actually the thing that you think is
5 most important? Not critical.

6 A. Did you say most important when
7 you asked the question the first time? I don't
8 think you said most important.

9 Q. Strongest feature.

10 A. I think that's one of the things
11 that separates us from the rest of the industry.

12 Q. And is there a piece of this that
13 you feel is the weakest feature of the program
14 right now?

15 A. No.

16 Q. And you talked about your
17 competitors -- and I know that they are your
18 competitors. But how does Cardinal's
19 anti-diversion program differ from your
20 competitors, to the extent you know?

21 A. I don't know how they evaluate
22 customers and set thresholds. I just know that
23 our -- what you referred to earlier, that
24 50 percent, that functionality will ensure that

1 the orders are always going to make sense,
2 whether we're distributing 100 percent of a
3 customer's volume, 50 percent, or 10 percent, or
4 anywhere in between. Like, that's probably the
5 big differentiating factor.

6 Q. Okay. So in this round of
7 Jeopardy, we're going to be turning to Montana
8 in particular.

9 A. It's not been Double Jeopardy yet?

10 Q. Right. This is the lightning
11 round.

12 Did you have a chance to look at
13 the suspicious order spreadsheet that Cardinal
14 provided to the State of Montana?

15 A. I'm not sure.

16 Q. Okay. I hope your vision is good.

17 A. It is up close.

18 - - -

19 (Montana-Cardinal Exhibit 6 marked.)

20 - - -

21 Q. So showing you Exhibit 6. So this
22 is -- you're welcome to borrow mine. This is a
23 report that was produced to the State of
24 Montana. It lists all of the suspicious order

1 reports that Cardinal filed with DEA for the
2 State of Montana from 2013 forward.

3 A. Okay.

4 Q. So we'll let you look at that for
5 a minute.

6 A. And all the pages are the same,
7 right; it's just more data?

8 Q. Right. So they're different
9 orders --

10 A. Yes.

11 Q. -- but in the same format.

12 A. The headers are all the same.

13 Q. Exactly.

14 A. Got it.

15 - - -

16 (Montana-Cardinal Exhibit 7 marked.)

17 - - -

18 Q. These were the two documents that
19 we obtained from Cardinal that list suspicious
20 order reports. So obviously Exhibit 7 that you
21 were given is text fields. Very hard to read.
22 But I wanted you to have the two reports that
23 were produced to us.

24 A. Yes.

1 Q. Okay. And I'm not going to ask
2 you specifics about individual orders.

3 A. Okay.

4 Q. I just wanted you to have the
5 spreadsheets in front of you.

6 So in Exhibit 6 with the
7 columns --

8 A. Yes.

9 Q. -- I think -- does it have a title
10 on it?

11 A. It does not.

12 Q. Okay.

13 A. I mean, the columns have headers,
14 but there's no title on the document.

15 Q. Okay. So do you recognize Exhibit
16 7, the text fields? Is that something you've
17 seen before? Can you parse what that is? It
18 was listed to us as "reported to DEA case."

19 A. The individual pieces on here are
20 obviously familiar to me, but the format of it
21 I'm not sure.

22 Q. Okay. We'll do our best muddling
23 through them.

24 So on the spreadsheet -- not the

1 text file. Exhibit 6.

2 A. Yes.

3 Q. There are 323 transactions.

4 A. Okay.

5 Q. But there are only 289 on the text
6 file version.

7 A. Okay.

8 Q. Can you explain to us why there
9 would be a discrepancy between those reports, if
10 you know.

11 MS. WICHT: Could you say the
12 numbers for me again, Linda? I'm sorry.

13 MS. SINGER: So Exhibit -- one
14 exhibit is CAH_MTAG, Bates number 1329.
15 And the other is CAH_MTAG_1750, which
16 was called "Reported to DEA case."

17 A. How much was on the first one?

18 Q. I'm sorry. 1329, Bates number
19 1329, is orders reported to DEA. 1750 is orders
20 held by Cardinal's system in Montana. That's
21 the difference.

22 A. How many were on the big one?

23 Q. What?

24 A. How many were on the big

1 spreadsheet?

2 Q. So on the big one -- let me just
3 double check. 1329 --

4 A. Okay.

5 Q. -- is 323.

6 A. 323?

7 Q. Mm-hmm.

8 A. Okay.

9 Q. And 1750 is 289.

10 A. And tell me what you called

11 Exhibit 6.

12 Q. Now you're really --

13 A. Sorry.

14 Q. Exhibit 6, the spreadsheet, is
15 orders reported to the DEA.

16 A. Okay.

17 Q. And 1750, which is Exhibit 7, is
18 orders held by Cardinal's system.

19 A. And we think the time frames are
20 identical?

21 Q. Yes. 2013 forward.

22 And, again, this is not a math
23 test. If there's an obvious reason to you why
24 there would be a difference in the numbers,

1 that's what we're trying to understand.

2 THE WITNESS: Speak?

3 MS. WICHT: I think so. But do
4 you have a concern about privilege? Is
5 that what you're --

6 THE WITNESS: Huh-uh.

7 MS. WICHT: Oh, yeah. Go ahead.

8 A. So my first question would be:
9 Are the start and end dates identical? That
10 would be my first question.

11 Q. So we do believe so, because they
12 were produced by you to us for the same period.
13 So let's assume that's the case. Is there a
14 reason that you can think of as a data or policy
15 matter that there would be different numbers
16 here?

17 A. There is. Although, based on the
18 titles -- and the titles could have gotten
19 flip-flopped, but when I heard you say --

20 Q. Including by me, in fairness.

21 A. When I heard you say 323 and
22 289 --

23 Q. Yes.

24 A. -- that my initial reaction would

1 have been one was held orders. And then the
2 lower number was the ones that were actually
3 canceled and reported as suspicious. So the gap
4 would have been the orders that were viewed and
5 then released.

6 Q. Okay.

7 A. That would be my initial -- not
8 knowing any more than what I have in front of
9 me, that would be my initial reaction.

10 Q. So an order that the larger number
11 is larger, because not every order that's
12 reported is ultimately -- no. Other way around.

13 A. Every order -- yeah. So not every
14 order that hits a threshold is canceled and
15 reported. The majority are. But based on this,
16 my assumption was the slightly larger number
17 were the ones that hit the threshold.

18 The slightly smaller number were
19 the ones that were canceled and reported. And
20 the gap between the two would have been the
21 number that were released. That's strictly me
22 speculating based on what I'm looking at.

23 Q. So why would an order that
24 exceeded threshold --

1 A. Yes.

2 Q. -- be released and not reported?

3 A. So it would depend on a lot of
4 different factors. It could be that we changed
5 the threshold. Again, back to the conversation
6 we had around gaining information, we could have
7 changed the threshold. It could have been --

8 Q. So changed the threshold after the
9 order came in?

10 A. Yes. Exactly. So threshold came
11 in, evaluate it, and decide to raise the
12 threshold. Therefore, you release. I don't
13 want to get into too much inside baseball.

14 Q. We're here for inside baseball.

15 A. Not from a privileged standpoint,
16 but just from a system nerd standpoint.

17 One thing that happens, when we
18 change a threshold during the month, every
19 subsequent order that goes over what the amount
20 was prior to the change until the next accrual
21 cycle reset looks like a released order.

22 Q. Okay.

23 A. And that throws -- so then you
24 could have ten orders that look like hit the

1 threshold -- well, they didn't hit the new
2 threshold. So that's the way the system tracks
3 it. So that's a factor as well.

4 Q. So what you're saying is
5 effectively the system doesn't recognize the
6 threshold increase?

7 A. Until the next accrual cycle
8 reset. But that's not necessarily all the
9 instances, but that is one factor.

10 Q. And how would you figure that out?
11 Is there a way forensically?

12 A. You could, yes.

13 Q. Okay.

14 A. You could manually go through and
15 look at what a threshold was when it was
16 changed.

17 Q. So Jen is now thinking about the
18 request that's coming to her tomorrow.

19 Another question we had in looking
20 at this data is that we observed that in a
21 number of instances, Cardinal filed a suspicious
22 order report. So it's not that delta we're
23 talking about between them.

24 A. Yes.

1 Q. They're on both.

2 A. Yes.

3 Q. They were reported.

4 A. Yep.

5 Q. But then the same NDC product is
6 shipped to the customer days later.

7 A. Not uncommon. It would depend on
8 when that accrual reset took place, that if
9 there was a new accrual period, the threshold
10 does reset. And if we determine that there's no
11 concerns of diversion, we should continue to
12 supply that customer, we would continue to
13 supply to them.

14 Q. So, again, it just reinforces the
15 same point you made earlier --

16 A. Yes.

17 Q. -- that an exceedance is not
18 necessarily a suspicious order?

19 A. Correct. It is a suspicious order
20 by definition of the suspicious order. It's not
21 necessarily indicative of diversion at the
22 customer level.

23 I can't believe you can read this
24 one. It's like giving me a seizure.

1 Q. We pull out no stops getting our
2 testimony. The strobe light happens next.

3 A. That's what it feels like.

4 Q. In some of the reports, there is a
5 negative shipped quantity and dosage units,
6 just, again, as a general matter.

7 A. Can you show me where you're
8 seeing that?

9 Q. It's going to be another
10 spreadsheet, 1369.

11 MS. SINGER: Is that what you've
12 got?

13 All right. So we're going to need
14 another exhibit number.

15 - - -

16 (Montana-Cardinal Exhibit 8 marked.)

17 - - -

18 Q. So I can't direct you to specific
19 lines, but some of them have negative numbers.

20 A. Okay. So this is not suspicious
21 orders. This is just distribution data.

22 Q. That's right.

23 A. Yes. And if you see a negative
24 number, because you are identifying a specific

1 window of time, for example, in this case 2016,
2 the net number during that time was negative 60.

3 So they may have purchased --

4 Q. And returned?

5 A. Yes.

6 Q. Okay.

7 A. And the returns during that time
8 frame were greater than the purchases. So it
9 would show a negative number.

10 Q. Not your favorite customers?

11 A. It depends.

12 Q. So going back to -- I'm sorry. In
13 the same one, 1369, Exhibit 8.

14 A. Yes.

15 Q. Why would there be records of
16 shipment by Cardinal Health to Montana customers
17 that are in the ARCOS data --

18 A. Yes.

19 Q. -- but not on that shipment
20 report?

21 A. And tell me what this shipment
22 report is.

23 Q. Again, it is, I think, the list
24 you all produced of opioids distributed in the

1 State of Montana by Cardinal.

2 MS. WICHT: And you're comparing

3 to ARCOS data produced by DEA in the

4 context of the litigation?

5 MS. SINGER: Yes.

6 MS. WICHT: Okay.

7 If you know. If you know, you can

8 answer.

9 A. I don't know. The only -- so,
10 again, I have no idea. But if I were to guess,
11 one possible reason would be there are drugs
12 that are included in Exhibit 8 that are not
13 ARCOS reportable drugs, and that could be a
14 factor in this.

15 I don't know that for sure because
16 I don't know how this was pulled or any of that
17 stuff. That's a guess. I mean, so a great
18 example is when I look at this, DEA base code
19 5001 is tramadol. And, for example, tramadol
20 was not a controlled substance in 2013. So
21 that, I assume, would not be in ARCOS data.

22 Q. Okay.

23 A. If that makes any sense.

24 Q. Yes.

1 And can you also explain -- I'm
2 not going to trouble you with the exhibit,
3 because it's just a lot more paper. But are
4 there instances where Cardinal would ship more
5 than a customer ordered?

6 A. No.

7 Q. Okay. We found 157 examples of
8 that.

9 A. And how are you seeing the order?

10 Q. Again, this was --

11 MS. SINGER: Do you have 1371?

12 MS. DEYNEKA: It's the
13 distribution of opioid medications to
14 Montana on a per order basis from 2006
15 to 2018.

16 MS. WICHT: That's what Exhibit 8
17 is -- or no. That's what you're
18 comparing.

19 A. So you're seeing an order for 100,
20 and you see a shipment of 110, for example.
21 Again, not being involved in how any of that was
22 created, my initial response to that would be I
23 don't know if maybe there was a backorder
24 situation where a product could have been on

1 backorder. And then the backorder order would
2 have been released that would not have been tied
3 to that individual order that came after the
4 fact. And you could have the backorder material
5 becomes part of the same order. That would be
6 my initial reaction. But, again ...

7 Q. Okay.

8 MS. SINGER: Why don't we do 1728.

9 Q. You think these are questions to
10 you. This is really a test for Natalie.

11 A. She's doing a good job.

12 - - -

13 (Montana-Cardinal Exhibit 9 marked.)

14 - - -

15 Q. So we understand Exhibit 9, which
16 is CAH_MTAG_1728, to represent -- to include at
17 the back 17 --

18 A. So wait. These are the working
19 instructions you had.

20 Q. I see you feel very vindicated by
21 that.

22 Let me ask you a general question.

23 When we see a customer with a threshold level
24 set at 99,999 or 999,999,999, what does that

1 mean?

2 A. So that is a systematic issue to
3 the subbases that we spoke of earlier, that we
4 may have had a subbase code in place for that
5 customer at one point in time. And then when we
6 changed the subbase, again that base will
7 encompass, for example, hydrocodone -- all
8 hydrocodone strengths, sizes, brand, generic,
9 immediate release, extended release, everything
10 involved in the hydrocodone family.

11 We do not want the subbase, which
12 was a subset of that number, to affect the base
13 code. So the system gives it what looks like a
14 huge number to ensure that it will always be
15 greater than the base. Therefore, the base code
16 will always take effect.

17 Q. But if the point of the subbase
18 code --

19 A. Yes.

20 Q. -- was to flag or restrict sales
21 of more likely to be diverted --

22 A. Yes.

23 Q. -- products --

24 A. Yes.

1 Q. -- why would you want to eliminate
2 that?

3 A. Because they got put in place --
4 so, for example, the one that you're probably
5 looking at might be Zohydro. And when Zohydro
6 came out, we were concerned because of the
7 strength of the product, that it might become
8 the next thing, and it didn't.

9 In fact, the volumes are
10 .1 percent of hydrocodone volume, and very
11 non-existent and rare. So that's why we took
12 that off so it would not affect the other
13 pieces.

14 Q. Okay. We may be saving Natalie
15 then.

16 A. But on the surface, it looks like,
17 oh, my gosh, what is this huge number. And it's
18 system issue to ensure that the number will be
19 greater than the base code and it won't affect
20 the base code.

21 Q. So we saw with some frequency,
22 too, with buyers who were terminated and then
23 restored, and then they would come back with
24 thresholds at 999,999.

1 A. What do you mean when you say
2 buyers that were terminated?

3 Q. So some -- again, what we
4 understand to be is customers were -- they could
5 no longer purchase controlled substances.

6 A. Okay.

7 Q. They're listed in the documents as
8 terminated.

9 A. Okay.

10 Q. Not just orders that were held or
11 deleted.

12 A. Yes.

13 Q. And then they came back. It will
14 say "termination restored" or "customer
15 restored" or something like that. And then the
16 threshold listed is 999,999.

17 A. For the subbase, not for the base?

18 MS. SINGER: Did you find that
19 spreadsheet?

20 MS. DEYNEKA: I'm working on it.

21 BY MS. SINGER:

22 Q. All right. We'll skip it for now.
23 We can always deal with it separately.

24 A. And it's tricky. When you're

1 going through it, you've got to go back and make
2 sure you find the base code, because the base
3 code will trump the subbase.

4 Q. Okay. Why would you terminate a
5 buyer for certain opioids but not all opioids?

6 A. Do you have a specific example?

7 Q. I think you know the answer to
8 that.

9 A. Can I see the specific example?

10 Q. I can to show you that it
11 happened. There were a number of cases of it.

12 A. Do you have time, date ranges?

13 Q. I don't. They are knowable. I
14 don't know them sitting here.

15 A. That would not be a normal
16 procedure.

17 Q. Okay. Meaning if you find that a
18 customer is suspicious with respect to
19 hydrocodone, you're going cancel all of their
20 privileges?

21 A. Yes.

22 Q. And that would be what you would
23 expect to be the appropriate response?

24 A. Yes.

1 Q. Okay.

2 A. Very similar to your Mallinckrodt
3 questions. Mallinckrodt is for --
4 Mallinckrodt's oxy, we cut them off for all
5 controls.

6 Q. Okay. Does Cardinal supply
7 physicians directly?

8 A. Not through its pharmaceutical
9 distribution business.

10 Q. Okay. Meaning Cardinal does, but
11 not within your purview?

12 A. Not within the pharmaceutical
13 distribution business. There's another business
14 that does that, but we do have thresholds in
15 place for those as well.

16 Q. And are you responsible for
17 anti-diversion efforts with respect to those
18 sales?

19 A. Yes.

20 Q. And was there a period when
21 Cardinal started looking at its supplies to
22 individual physicians?

23 A. I believe -- and this is before my
24 time -- that at one point in time, there was

1 distributions from PD to physicians offices, but
2 that's not the case today.

3 Q. Okay.

4 A. It gets tricky because clinics,
5 physical clinics, use physician registrations
6 that it might look like it's a doctor himself,
7 but it's the doctor's DEA registration that the
8 clinic is registered under.

9 Q. Okay. And are there instances
10 where it would be reasonable or expected that a
11 customer is terminated with respect to one
12 distribution center but not another?

13 A. No.

14 Q. Okay. I have an example of that
15 one.

16 A. I know you do.

17

18 A. Yes.

19 Q. Can you explain it?

20 A. Can you tell me what the -- is one
21 of them either Denver or Salt Lake and the other
22 one is Wheeling, West Virginia?

23 Q. So the number of I have, which may
24 reveal that to you, [REDACTED]

1 A. Do you have like data --

2 Q. I don't have --

3 A. -- transactional data.

4 (Discussion off the record.)

5 Q. And then the last general question

6 is: We found instances where Cardinal

7 terminated a non-customer. Why would that

8 happen?

9 A. So I do not know the specific
10 example that you're referring to. But I could
11 tell you, for example, in some of the media
12 pieces that we had talked about earlier, that if
13 we see a pharmacy gets rated or busted that is
14 not a customer, we will try to put a block in
15 place to ensure that customer never comes on
16 board.

17 Q. Okay. And so we found with [REDACTED]
18 [REDACTED], Columbia Falls -- that was a
19 pharmacy that was terminated 7/13/2017 and
20 termination lifted 7/14/2017.

21 Why would that happen? 414,860
22 dosage units.

23 A. And the 414 is what time frame?

24 Q. I think -- I don't know. I don't

1 know.

2 A. So it sounds like they were cut
3 off for one day is what the data -- I would need
4 the data.

5 Q. Okay. See, after this experience,
6 you're going to know Montana so well.

7 A. Right? Yes.

8 Q. I know you said earlier when we
9 talked about the buffer in threshold --

10 A. Yes.

11 Q. -- that that's going to be
12 individualized.

13 A. Yes.

14 Q. And how much of a buffer and
15 whether there's a buffer will depend on the
16 customer.

17 A. Yes.

18 Q. However, is it true that the
19 buffer shouldn't give a huge amount of extra
20 capacity, right? You want to give some room,
21 but a buyer shouldn't have double its sales in
22 threshold?

23 A. It would -- conceptually that
24 makes sense. It would depend on the volume. So

1 if it was 2,000 and going from 2,000 to 4,000,
2 that's different than going from 60,000 to
3 120,000. But yes.

4 Q. Okay. In general, thresholds
5 should have a proximity --

6 A. Yes.

7 Q. -- to actual sales?

8 A. Yes.

9 Q. Okay. We found certain of your
10 buyers didn't have thresholds at all. Why is
11 that?

12 A. Again, I would need to look at and
13 understand exactly what you're looking at, who
14 the customer was, what the time frame is. I'm
15 not sure what data they got.

16 Q. Okay. Just asking generally.

17 And then the last couple general
18 questions we have from the data is -- there are
19 customers for whom you set thresholds where we
20 have no evidence that you sold them anything in
21 the relevant time period. Why would that be?

22 A. It could have been a customer that
23 came on board that through that Know Your
24 Customer process said they were going to buy X

1 and they never did.

2 Q. Does that happen?

3 A. Yeah.

4 Q. Okay.

5 A. Yeah.

6 Q. And then the data we have shows a
7 reason for a threshold change. I assume that's
8 something that has to be put into the system
9 when a threshold is changed?

10 A. Yes.

11 Q. So the reason it says "threshold
12 change to align with scripts volume and
13 historical purchase" --

14 A. Yes.

15 Q. -- what does that reflect?

16 A. So that would be a situation where
17 the overall script volume, the total control and
18 non-control, has changed up or down that would
19 have led to that contextual picture of the
20 customer looking different and making the change
21 to the threshold.

22 Q. Okay. Has Cardinal become aware
23 of customers taking steps to try to evade
24 thresholds or other compliance efforts?

1 A. No.

2 Q. So you've not seen reports of
3 structuring or other efforts to make orders in a
4 way that avoids your screens?

5 A. Conceptually that totally makes
6 sense. But, no, I've not seen specific
7 instances of that.

8 Q. Okay. And thresholds are sent for
9 monthly periods and yearly; is that correct?

10 A. We have daily, monthly, and
11 quarterly.

12 Q. But not yearly?

13 A. But not yearly.

14 Q. And the quarter, is that also like
15 the monthly, a fixed --

16 A. Yes.

17 Q. -- date?

18 A. Yes. It's three of the months.

19 Q. We saw that some of the data was
20 modified to reflect consistent historical sales
21 data.

22 A. I'm not sure what that means.

23 Q. So it's a field you had in the
24 data that changed threshold and then said

1 "consistent historical sales data."

2 Do you know what that refers to?

3 A. Not without seeing the specific
4 example, I wouldn't, no.

5 Q. Okay. So that phrase doesn't mean
6 anything to you?

7 A. Say it to me one more time.

8 Q. Consistent historical sales data?

9 A. No. That accompanied the
10 threshold change?

11 Q. Yes.

12 A. No.

13 MS. SINGER: Okay. So we're going
14 to mark this as 10. Is that what we're
15 up to?

16 - - -

17 (Montana-Cardinal Deposition Exhibit 10 marked.)

18 - - -

19 Q. It's not Bates numbered. So at
20 the page that is pulled back, you can see on the
21 very bottom in the far right field --

22 A. Okay.

23 Q. -- is the field that I was
24 referring to.

1 A. Got it. All right. I'm sorry.

2 So you're asking me about what that means?

3 Q. Yes.

4 A. So when I look at this --

5 Q. And the field, just so we have a
6 clear record, that you're referring to is?

7 A. "Threshold changed to align with
8 scripts volume and historical purchases."

9 So when I look at this specific
10 page, my assumption in looking at this is that
11 there was a mass update change. So there was a
12 decision made around threshold setting
13 methodology that got applied to everybody that
14 shouldn't have been applied to that customer
15 because we could have been going through a
16 process to take buffer out. And then that
17 process impacted that customer's level. And
18 this was returning it back to the previous level
19 before the mass change reduced it.

20 Q. Do you remember what kind of
21 global changes that Cardinal made during your
22 tenure, what kind of changes were made to
23 threshold setting?

24 A. A lot of the drugs have floors

1 that's a minimum that everybody can get, that
2 we've made a lot of changes to the floors of
3 various drugs over the years.

4 Q. And a floor, meaning unless you
5 ordered that much, you couldn't have any?

6 A. No. Floor would be the smallest
7 amount that everybody gets.

8 Q. Okay. So you couldn't purchase a
9 volume less than that?

10 A. You could. Your threshold will
11 just be at that -- almost the lowest common
12 denominator for a threshold.

13 Q. Understood. It is the threshold
14 for everybody who buys anything?

15 A. Yes. And then if you get more
16 than that, that's where the methodology comes
17 into play, yes.

18 Q. Okay.

19 A. That would be one example.

20 Q. Okay. When we talked about the
21 size of increases --

22 A. Yes.

23 Q. -- and whether that triggered a
24 concern about potential diversion, and you said

1 it depends on a lot of different things.

2 When you're looking at increases,
3 are you looking at that month to month, order to
4 order, year over year?

5 A. It would vary, but month to month
6 would be the most common.

7 Q. Okay. So a customer that
8 increases by a little bit every month, how is
9 Cardinal picking up?

10 A. Back to the concept of setting
11 that initial threshold properly, there's -- once
12 you move -- so to your question, increase it,
13 you're going to hit a zone that's going to
14 require two-person approval, LV TAC approval,
15 those type of pieces. So you can't have
16 unlimited -- there are lines that dictate once
17 you hit the zone, it's got to be reviewed by
18 multiple people.

19 - - -

20 (Montana-Cardinal Exhibit 11 marked.)

21 - - -

22 Q. All right. So you could take a
23 minute and look, but Exhibit 11 is an e-mail
24 from you Friday, January 11, 2008, correct?

1 A. Yes.

2 Q. So one thing that's curious about
3 this, is this is before you moved into
4 anti-diversion.

5 A. Correct.

6 Q. And so how -- you can read the
7 communication obviously before answering that.
8 But the first question will be: How were you
9 involved in this chain before you were involved
10 in compliance?

11 A. Okay.

12 Q. So how were you involved in this
13 chain from your previous role?

14 A. So in reading this e-mail, and not
15 remembering exactly the specifics of this, when
16 I was in the sales office and involved in
17 customer data, this team came to me and was
18 asking for me to produce data from a reporting
19 standpoint to give to them to allow them to
20 analyze the components that they were looking to
21 analyze as they were building out an IT solution
22 in the bigger picture.

23 Q. Okay. So in the e-mail at
24 CAH_MDL_PRIORPROD-DEA07_111090 --

1 A. Yes.

2 Q. We're actually going to do 92.

3 A. 92?

4 Q. Yes. So it talks about threshold
5 creepers.

6 A. Yes. Wait. Let me find it. Are
7 you on the top half or bottom half?

8 Q. It's right in the middle of the
9 page.

10 A. Okay.

11 Q. What is a threshold creeper, and
12 what has Cardinal done to deal with it?

13 And, you know, before you answer
14 that actually, so if you can read the second
15 paragraph of the e-mail from Michael Mone.

16 A. Same page?

17 Q. Yep. To Mark Hartman. It says --
18 it talks about "the potential for diversion
19 through a process of small adjustments --

20 A. Yes.

21 Q. -- that result in large changes
22 over time."

23 A. Yes. That's exactly what you just
24 asked me about.

1 Q. Yes.

2 A. Yes.

3 Q. So these threshold creepers. So

4 this is 2008.

5 A. Yes.

6 Q. How has Cardinal dealt with it?

7 A. We have established the zones
8 that, again, as you move from one zone to the
9 other, we've got increased scrutiny on the level
10 of approval that needs to take place to move.

11 Q. Okay.

12 A. And I don't know that that didn't
13 exist back then from reading this e-mail, but
14 that's the concept.

15 Q. Okay. Meaning that when you've
16 moved more than a certain amount or moved
17 over -- or were requiring a certain increase in
18 threshold --

19 A. Yes. So --

20 Q. -- there has to be -- go ahead.

21 A. Yeah. You're right. So you were
22 asking me what's the difference between going
23 from 0 to 50 versus 2 for 25 months. That's
24 where the zones come into play that looks at

1 volume. And when you hit a certain stage,
2 whether it's multiple increases or one increase
3 that got you to that, that's when the two-person
4 approval -- that's when it has to come to my
5 level. That's when it has to go to LV TAC.

6 Q. And what is that trigger?

7 A. It varies by the specific drug.
8 Higher for some, lower for others, depending on
9 what the normal usage would be. And then the
10 context of the size of that customer from a
11 total script perspective.

12 Q. Okay. So are you saying that for
13 oxycodone, for instance, the permissible
14 increase is X percent, and that will be
15 different than the percentage increase that's
16 permitted for fentanyl or a different drug
17 class?

18 A. Yes. It's tied to volume, not
19 percent increase.

20 Q. Okay. So explain that.

21 A. To your point earlier of "I could
22 have 100 as an increase because it went from
23 1,000 to 2,000, but you could be at 100,000 and
24 only go up 10 percent, but that's 10,000 pills,

1 a much bigger jump than 1,000. That's why it's
2 based off the volume of the individual drug
3 class. And as that increases, that's where that
4 scrutiny comes into play.

5 Q. Okay. And where are those volumes
6 reflected in Cardinal's SOPs or working
7 guidelines or whatever it may be? Where is it?

8 A. So if you look at --

9 Q. It is written down somewhere?

10 A. Yes.

11 Q. And it sets the specific volume by
12 drug?

13 A. Yes.

14 MS. SINGER: Go ahead. You ask.

15 MS. DEYNEKA: If at some point the
16 policy didn't have zones created, would
17 that have created a significant problem
18 for diversion?

19 THE WITNESS: I don't know what
20 they did or didn't have placed outside
21 of the zone concept at that point in
22 time.

23 Obviously it's something based on
24 the e-mail they're aware of. And,

1 again, I don't know what behind the --
2 out of my purview conversations took
3 place on how they addressed it.

4 BY MS. SINGER:

5 Q. Okay. We identified four pharmacy
6 customers in Montana, and we asked Cardinal to
7 produce all of the diligence files related to
8 those customers. We just want to show them to
9 you and make sure we have everything that would
10 go in a typical file. So this will be Exhibit
11 12.

12 - - -

13 (Montana-Cardinal Exhibit 12 marked.)

14 - - -

15 Q. All right. So this relates to --
16 MS. SINGER: Which pharmacy is
17 this?

18 MS. DEYNEKA: Plaza United.

19 BY MS. SINGER:

20 Q. This is the Plaza United Pharmacy,
21 which is where? I have an address but not a
22 city. So it is on 11th Avenue.

23 And if you could just take a
24 minute and look at this. These documents, first

1 of all, would have come from what system within
2 Cardinal?

3 A. So are you looking at 1798?

4 Q. Yes. So we're looking at just for
5 the record CAH_MTAG_1798.

6 A. So this appears to be what
7 probably was at that point in time the Know Your
8 Customer document. Now, I say that. This also
9 could have been a questionnaire that they could
10 have had the customer fill out if there was a
11 potential threshold event. It could be that as
12 well.

13 Q. Okay. And then we move to
14 CAH_MTAG_1805.

15 A. So this looks like the new -- this
16 is the actual new customer. This was probably
17 the threshold event questionnaire, and this
18 looks like the new customer.

19 Q. Meaning that this is the raw
20 questionnaire that then got entered into the
21 system producing 1798?

22 A. Yes. I'd look at 1805 as this was
23 the information that was gathered upon the
24 onboarding. And then this was information that

1 was gathered at some point in the future from
2 the customer.

3 Q. Okay. All right. And then
4 CAH_MTAG_1812?

5 A. This is two minutes after 1798.
6 So my guess is that 1812 is some type of
7 verification on who filled out 1798.

8 Q. And so this is an e-mail --

9 A. Yes.

10 Q. -- to Sherry Morse.

11 How are e-mails captured in your
12 system and associated with a customer record?

13 MS. WICHT: From Sherry Norris.

14 MS. SINGER: Yes. I'm sorry.

15 Thank you.

16 A. In this specific example, this
17 e-mail went into a group mailbox that I assume
18 was done for storage purposes.

19 Q. Okay. And so if a regulatory
20 person or a sales rep e-mails a customer with a
21 question related to a threshold exceedance issue
22 you may have found, how does that get captured
23 in the system?

24 A. If an e-mail was sent, it would be

1 kept in the e-mail system itself.

2 Q. And is there any mechanism that
3 ties it to the customer profile or the customer
4 file?

5 A. I don't think so.

6 Q. Okay.

7 A. I mean, there could have been back
8 then when they were e-mailing customers, but --
9 yeah.

10 Q. Okay. But not to your knowledge
11 now?

12 A. No.

13 Q. And then CAH_MTAG_1813 seems to
14 start a series of DEA --

15 A. License verification.

16 Q. Okay. So when an investigator
17 looks up a pharmacy's registration or a
18 pharmacist's registration, you all capture that
19 someplace?

20 A. Yes.

21 Q. And explain what's done there.

22 A. This is -- again, based on when
23 this was done -- I don't know if this was part
24 of the onboarding or happened later on in the

1 process, but we're just verifying the state and
2 federal licenses active for the pharmacy. Part
3 of our Know Your Customer process.

4 Q. And when an investigator does
5 that, right, you capture all of this --

6 A. Yes.

7 Q. -- so that you can show that it
8 was done?

9 A. Yes.

10 Q. Okay. So everything an
11 investigator does to investigate either a new
12 pharmacy, a Know Your Customer, or a suspicious
13 order threshold exceedance is going to be
14 documented and kept for the file?

15 A. Let me hear you say that one more
16 time.

17 Q. Everything that an investigator
18 does to investigate a new customer -- doing a
19 Google search, looking up the pharmacy, all of
20 that is going to be kept and loaded into the
21 customer's file?

22 A. Yes.

23 Q. Okay. And same is true when you
24 are investigating a threshold exceedance or

1 other event that peaks suspicion?

2 A. It would depend on what that
3 investigation included. There could have been a
4 phone call that might have happened between the
5 analyst and a customer. That might not be
6 documented. So there could be some
7 correspondence that might not actually get
8 documented. But if a change was made, we would
9 document the reason for the change.

10 Q. Okay. And the investigation that
11 was done in connection with that change, if it
12 wasn't a phone call but some search that the
13 investigator did, all of that is going to be
14 captured?

15 A. Yeah. All the reasoning for the
16 change would be captured.

17 Q. Okay. And the backup for it?

18 A. Depending on what it was. So it
19 may be, like what you saw, script volume --
20 overall script volume increase -- like that is
21 what I mean when I say captured. While you
22 change the threshold, you would put in what the
23 justification was for the change.

24 Q. Okay. But if the investigator did

1 a Google search on the customer, they're going
2 to print that out and add it to the file?

3 A. So I'm making that face, because
4 when you say "investigator." So -- they would
5 do that from an onboarding process. As far as
6 in regards to a threshold event, I don't know
7 that that necessarily would get printed out from
8 a -- if for whatever reason they were doing some
9 type of Google -- but, again, in the
10 documentation, if they changed the threshold,
11 they would document the reason for the change.

12 Q. Okay. Meaning that if the
13 investigator had increased the threshold and had
14 verified that a hospice had opened in the
15 area --

16 A. Yes.

17 Q. -- that's all going to be
18 reflected that in that field?

19 A. Yes.

20 Q. And if they did a Google search to
21 verify that there was a new hospice center --

22 A. I see what you're saying. So in
23 your example, that would not be something that
24 we would necessarily Google search. If the

1 customer said based on what opened, that's where
2 we would be looking at, the volumes from that
3 customer, and -- everything that they're
4 purchasing, non-control and control mixes,
5 indicative of what supplying a hospice facility
6 would look at, that's what we would be
7 verifying.

8 Q. Right. So you may decide for the
9 reasons you said earlier that you don't need to
10 verify it. But if you do verify it, is there
11 going to be a paper trail?

12 A. Yes.

13 Q. Okay.

14 A. Yes.

15 Q. All right. So let's keep going
16 through this file. So we've gone through the
17 license lookup. Then CAH_MTAG_1819 and on is
18 the Ryan Haight Online Pharmacy survey?

19 A. Yes.

20 Q. Okay. Is that something that's
21 verified, or is it a pure customer
22 representation?

23 A. It's customer representation.

24 Q. And then 1821 is another

1 registrant lookup. Now, it looks like all of
2 these lookups are pharmacists. Cardinal will
3 check the licensing of every pharmacist?

4 A. It depends on the type of
5 customer.

6 Q. Meaning?

7 A. For example, with a CVS that could
8 have 30 pharmacists that could work at that
9 pharmacy and other ones, we wouldn't be able to
10 verify every single individual. What we are
11 doing in this situation is verifying the
12 pharmacist in charge.

13 Q. Okay. And you also have here a
14 pharmacy tech --

15 A. Yeah.

16 Q. -- at 1828?

17 A. Yep.

18 Q. Again, everyone you look up,
19 you're going to have a record of?

20 A. Yes.

21 Q. You won't necessarily look up
22 everyone if it's a CVS?

23 A. Yes.

24 Q. Okay. And then 1830. QRA survey,

1 what's that?

2 A. This is a surveillance visit that
3 was performed by Martin Murphy who, I assume,
4 was the PBC assigned to that customer.

5 Q. Meaning the sales rep?

6 A. Yes.

7 Q. Okay. And do we know from this
8 what would have triggered that --

9 A. From this --

10 Q. -- site visit?

11 A. -- we don't. It could have been
12 because of a threshold event. It could have
13 been because based off the zone the customer is
14 in, we require these to happen on a specific
15 periodic basis. It could have been one that's
16 scheduled to happen that hadn't happened, or it
17 could have been threshold event driven.

18 Q. Okay. But whenever that site
19 visit or survey happens, that's going to be
20 captured?

21 A. Yes.

22 Q. Okay. And so from what you've
23 just gone through for Plaza United Pharmacy --

24 A. Yes.

1 Q. -- does this seem like a typical
2 diligence file for a customer?

3 A. Yes.

4 Q. Okay. Is there anything that
5 would go in a diligence file that --

6 A. Until you show me it's not.

7 Q. There's no trick up my sleeve.

8 Is there anything that you would
9 expect to be in that file that isn't there?

10 A. Not necessarily. Again, it would
11 depend on what the volume and ratios are of that
12 customer. If it were larger volume, there could
13 be investigative site visits that could take
14 place. There could be -- if it was reviewed by
15 LV TAC, there could be an LV TAC review memo
16 that could be in there.

17 Q. And if there was -- for instance,
18 it was a large customer, it was LV TAC memo,
19 it's going to be in there?

20 A. It should be, yeah.

21 Q. Okay.

22 A. Again, depending on how far back
23 you're going could dictate what's in there or
24 what's not in there.

1 Q. Okay. And is there a point at
2 which the records get dicey?

3 A. I don't know if I'd call them
4 "dicey" or not. But, for example --

5 Q. That was my word.

6 A. For example, LV TAC was created
7 out of the MOA with the DEA. So there would be
8 no LV TAC review prior to May of '12, for
9 example.

10 Q. Okay. And why was LV TAC created?

11 A. I don't know -- I wasn't involved
12 in any of the negotiation components obviously
13 of the MOA. But it's my understanding that it
14 was to ensure that the larger volume customers
15 were reviewed by senior leadership.

16 Q. And is there a difference between
17 an LV TAC customer and, for instance, a national
18 chain?

19 A. No.

20 Q. They're going to pick up the same
21 universe of customers?

22 A. Yes. Absolutely. It's all volume
23 and ratio driven.

24 Q. Okay. So are you familiar with

1 the disk track held order report?

2 A. I'm not familiar with that
3 specific report, but I'm familiar with disk
4 track and held orders.

5 Q. Okay. And you can run a report, I
6 believe, that lets you see how many held orders
7 there are at any particular moment; is that
8 right?

9 A. Yes.

10 Q. And is that an archive so that you
11 can see every order that's been held for a
12 customer, for instance, even if it's since been
13 released?

14 A. I believe so.

15 Q. And is that in disk track or
16 someplace else?

17 A. I believe it's in disk track.

18 Q. Okay.

19 A. I think.

20 Q. And there's a customer profile for
21 every customer, correct?

22 A. And when you say "customer
23 profile," you mean --

24 Q. I think it's in Winwatcher, maybe?

1 A. Well, tell me what you mean when
2 you say "profile."

3 Q. What?

4 A. Tell me what you mean when you say
5 "profile."

6 Q. It's basic demographics of a
7 customer. It's what you would use to get the
8 key details.

9 A. In relation to anti-diversion?

10 Q. Yes.

11 A. That wouldn't necessarily -- so
12 Winwatcher is the sales force automation tool.
13 So it's not our tool that it does thousands of
14 things as far as managing the business. So
15 there would be profiles in there, but they
16 wouldn't necessarily be related directly to
17 anti-diversion.

18 Q. Okay. And are there
19 anti-diversion profiles? And where do those
20 live? In the ADC?

21 A. Very good. There are -- yes.
22 And, again, I was hesitant to say "profile,"
23 because this could be a profile, some review of
24 volumes.

1 Q. "This" being the customer
2 diligence file?

3 A. Yes. That's why I wasn't sure
4 what you meant when you said "profile."

5 Q. But ADC is the system where you
6 collect all of the relevant information about a
7 customer, or at least a thumbnail of them?

8 A. Yes, most of the information.

9 Q. Okay.

10 A. Yes.

11 Q. And ADC, explain how that came
12 into being.

13 A. It is the tool that is used to
14 manage threshold and threshold events. So you
15 made reference to disk track. Disk track is the
16 pick, pack, and ship system that the orders come
17 into. The thresholds live in disk track, but
18 ADC interacts with disk track that when the
19 threshold event happens in disk track, it tells
20 ADC, and you go into ADC and you work the
21 threshold event.

22 Q. Okay. And, again, ADC will keep
23 all of that historical information. So if there
24 was --

1 A. I don't believe that ADC would
2 keep all the held order historical information.
3 I assume it has a dropoff window. Because it
4 actually happened in disk track. It didn't
5 happen in ADC. ADC was what was used to read
6 the information out of the disk track. If that
7 makes any sense.

8 Q. Okay. And so IBM came in to
9 develop ADC for you, correct?

10 A. I don't know. It was developed
11 before I came into the role. So I'm not sure
12 who did it.

13 Q. And I want to make sure we cover
14 as a tangent. So of the outside vendors and
15 consultants you've worked with who have either
16 helped in developing or evaluating various
17 aspects of the anti-diversion program, who have
18 you worked with?

19 A. As far as technology vendors?

20 Q. Any kind programmatic vendor
21 related to the anti-diversion program.

22 A. I have not worked with any
23 technology vendors since I've been in the role.

24 Q. Okay. And how about

1 non-technology vendors?

2 A. He's not a vendor. But Linden
3 obviously was heavily involved in the creation
4 of the program. And then the only other vendors
5 that we would work with would be the third
6 parties that we used to do site visits.

7 Q. Okay. And that's Cegedim
8 Dendrite?

9 A. Yeah, it's not now. And, again, I
10 don't know if -- it's a new -- I can't keep the
11 name -- so it's Cegedim, but then I think they
12 got bought by IMS, and it's Avantha.

13 Q. And so you use them basically as
14 additional investigators to help do site visits.

15 How many investigators do you have
16 on your staff to do site visits?

17 A. Seven.

18 Q. And how many distinct pharmacy
19 customers does Cardinal have who order
20 controlled substances from you?

21 A. Any controlled substance in any
22 volume?

23 Q. Yes.

24 A. I would guess 25,000 to 30,000.

1 Q. And if we were to narrow that down
2 by customers who buy opioids, is that a smaller
3 group?

4 A. Yes.

5 Q. And how much smaller?

6 A. 20,000.

7 Q. Okay. And so how many additional
8 outside investigators do you use through
9 Cegegim?

10 A. I don't know the number of
11 investigators. We give them a pool of customers
12 to do the visits on. I don't know how many
13 investigators -- we pay a price per visit, not
14 per investigator. So I'm not sure how many
15 investigators they have.

16 Q. Okay. And how many site visits do
17 you do in a year?

18 A. Which type?

19 Q. Tell me by type.

20 A. So we have surveillance visits
21 that the sales team does, which is that example
22 we just looked at a minute ago. We use third
23 parties to do surveillance visits. And then we
24 use our internal investigators to do what we

1 call full visits. It's what we talked about
2 earlier where they're going in, getting
3 aggregate level dispense data, looking at the
4 customer in totality. And then we will use a
5 third party to do the full visits as well when
6 we have scheduling issues.

7 We probably do 1,000 full visits a
8 year. And we probably do 40,000 sales
9 surveillance visits. And we probably do 2,000
10 third-party surveillance visits.

11 Q. Okay.

12 A. And those are all plus or minus.

13 Q. Okay. And when you talk about
14 visits, those may be visits to the same
15 customer, or does each of those represent a
16 distinct customer that you're seeing?

17 A. The 1,000 full visits would
18 represent 90 to 95 percent distinct customers.
19 So 900 to 950 would be distinct. The sales
20 surveillance visits would have overlap in them.

21 Q. Okay. And it's the full visit
22 that is the really check-under-the-hood visit?

23 A. Yes.

24 Q. And the -- I think you called it a

1 surveillance visit. That's done by a sales rep?

2 A. Or a third party.

3 Q. Or a third party?

4 A. Yes.

5 Q. What is involved in that?

6 A. It's going to the pharmacy. It's
7 checking out the parking lot, sit in your car,
8 look at the comings and goings, looking for the
9 long lines, the out-of-state license plates, the
10 vans of teenagers pulling up out front, the
11 pharmacy that has no front end line around the
12 door, chicken wire and FedEx boxes, those types
13 of things.

14 Q. And those are all going to be
15 documented in those questionnaires we saw in the
16 file?

17 A. Yes.

18 Q. And sales reps who do these -- I
19 just want to step back on that for a minute. So
20 sales reps get a straight salary and a bonus?

21 A. Yes.

22 Q. And their bonus is not related to
23 volumes of controlled substances sold; is that
24 correct?

1 A. Correct.

2 Q. Is it volume related overall
3 either in terms of volume of sales or new
4 customers?

5 A. It is tied to overall volume, yes.

6 Q. Overall volume of purchases?

7 A. Yes.

8 Q. Including controlled substances?

9 A. Yes. Not pulled out separately
10 with a separate target number, but it is a
11 subset inherently in the distributions.

12 Q. And do sales reps have any metrics
13 they need to meet in terms of numbers of new
14 customers or volume of sales or increase in
15 sales?

16 A. I don't know the answer to that
17 other than I know it varies probably by
18 territory, but I don't know exactly.

19 Q. Okay. But without knowing the
20 number, there are metrics. There are subfloors
21 they have to meet?

22 A. I don't know if there's -- to your
23 point, I don't know if there's a new business
24 metrics, for example. Again, that's why I would

1 say it would vary by territory. If you have a
2 very saturated territory where you have every
3 customer, you wouldn't have -- do you know what
4 I mean?

5 Q. And are there any expectations on
6 the number of surveillance visits that your
7 sales reps are going to do?

8 A. There is.

9 Q. How much is that?

10 A. It varies by territory based on,
11 again, the volume and contextual size of those
12 customers that we expect them to do visits on,
13 the customers that meet the criteria that we say
14 these are the customers that need to be visited.
15 And they've got to do it every 90 days.

16 Q. Okay. And what is the consequence
17 if a sales rep doesn't meet that metric?

18 A. It is reflected in their annual
19 performance review. And it makes their life
20 very difficult if that customer needs a
21 threshold change.

22 Q. In what way?

23 A. That we're not going to do it.

24 Q. Okay. And I take it there's no

1 disincentive from reporting a customer, meaning
2 that's not going to be held against a sales rep?

3 A. No. When we decide to cut off a
4 customer or if our threshold setting has a
5 dramatic impact on the customer's business that
6 causes them to decide to leave us, we back all
7 of that out of the customer's budget and
8 compensation and tracking so it doesn't affect
9 them in any way.

10 Q. Okay. And what happens if you
11 find -- if you terminate a customer or see a
12 pattern of suspicious orders and the sales rep
13 hasn't reported that customer, are there
14 consequences to that?

15 A. It would depend on the specific
16 customer and were we terminating them because of
17 volume outside of us that the sales rep wouldn't
18 have had visibility into. So it could.

19 Q. Are you aware of any instance
20 where a sales rep has been disciplined or
21 dismissed because they didn't report?

22 A. No. Unfortunately, it's actually
23 the exact opposite, that because it all comes
24 out of their compensation, they err on the side

1 of throwing everybody they can out in front of
2 the bus, because it doesn't matter to them if we
3 cut them off or not. So they're actually
4 overcutting off of the customers because it
5 doesn't affect their compensation any.

6 MS. SINGER: Okay. And I probably
7 have one more block to do. I realize
8 you all may want one more break before
9 we conclude for the day, so whenever you
10 want to do it.

11 MS. WICHT: Let's do it.

12 (Recess taken.)

13 MS. WICHT: So we have -- as we
14 discussed briefly off the record, have a
15 clarification from some testimony
16 earlier today that we'd like to offer.

17 So as we talked about, I'm going
18 to ask Mr. Cameron just one or two
19 questions just to introduce it and allow
20 him to make the clarification. And
21 then, of course, invite you to follow-up
22 on it as you deem appropriate
23 thereafter.

24 And it is -- I know this is

1 something that we consulted about over
2 the break. So this is a clarification
3 that's being made after Mr. Cameron had
4 a conversation with his counsel during
5 the break.

6 Okay. So, Todd --

7 THE WITNESS: Yes.

8 MS. WICHT: -- earlier this
9 morning we were talking about some
10 meetings -- three different meetings
11 that you've had with the DEA, remember?

12 THE WITNESS: Yes.

13 MS. WICHT: Okay. And the third
14 meeting in particular was one that
15 happened in 2018.

16 THE WITNESS: Yes.

17 MS. WICHT: And you had discussed
18 the fact that what you did at that
19 meeting was to present the program to
20 DEA and things of that nature, right?

21 THE WITNESS: Yes.

22 MS. WICHT: Okay. And I think
23 that Ms. Singer had asked a question
24 about whether there were -- what I wrote

1 down was something like a specific event
2 that had triggered the meeting.

3 THE WITNESS: Yes.

4 MS. WICHT: And I wanted to
5 clarify with you, for another person who
6 was participating in that meeting?

7 THE WITNESS: Yes.

8 MS. WICHT: Was there a specific
9 event that triggered the meeting?

10 THE WITNESS: Yes. So my
11 meeting -- my purpose of going to meet
12 with DEA was because previous leadership
13 had changed over. And the individuals
14 that were at the two previous meetings
15 were mostly gone from at least that
16 branch of the DEA.

17 So I had been instructed by my
18 boss to go and meet with the new
19 leadership and present the program to
20 them.

21 Linden came with me, because
22 Linden went to talk about suspicious
23 orders that we had identified internally
24 through our normal process that we had

1 canceled and not shipped, but the orders
2 through an IT glitch did not get
3 reported to DEA.

4 So Linden had gone to discuss with
5 DEA the orders that, again, had not
6 shipped but had not been reported and to
7 hear from DEA if DEA wanted those to be
8 submitted at the present time.

9 MS. SINGER: Okay. All right.

10 Well, thank you for clarifying that.

11 BY MS. SINGER:

12 Q. So that raises just two questions.
13 When had those orders not been reported? What
14 time period was this?

15 A. I believe it was 2012 through
16 2015.

17 Q. And how many orders does this
18 involve?

19 A. I don't know the exact number, but
20 it was around 14,000 and change.

21 Q. Separate orders?

22 A. Yes.

23 Q. And did they relate to particular
24 customers, or were they across the country?

1 A. They were across the country. But
2 the majority of them were related to the subbase
3 code concept that we had talked about earlier,
4 that when we had put that subbase code logic in
5 place, those orders were getting held. We were
6 canceling them based on customer review. But
7 they were not getting transmitted through the
8 normal transmittal process to DEA. But it was
9 coast to coast, top to bottom, no specific DC or
10 state. It was all across the board.

11 Q. And do you know how many of those
12 orders involved opioids?

13 A. I would assume the vast majority.

14 Q. And do you know what the volume of
15 opioids was that was --

16 A. For the orders?

17 Q. Mm-hmm.

18 A. I do not. I do not.

19 Q. And did the DEA take any action on
20 the basis of that disclosure?

21 A. No. I know that Linden had asked
22 them if they wanted us to submit them now. And
23 I know the DEA was going to get back to Linden.
24 I'm unaware of them getting back to him or not.

1 I don't think they have. But they would talk
2 directly to him.

3 Q. Are you aware of other instances
4 where there were similar technology issues that
5 related either to orders not being reported or
6 orders being shipped that should have been held?

7 A. I am not, no.

8 Q. Okay. And as a result of this
9 discovery --

10 A. Yes.

11 Q. -- what steps did Cardinal take to
12 understand the scope of it and to address it?

13 A. We had gone through an audit
14 process that had identified the need to ensure
15 that -- kind of some of your questions earlier
16 about ADC and disk track, that that linkage
17 existed.

18 So an audit process was put in
19 place back in 2015 to ensure that that was
20 taking place. What we hadn't done is we hadn't
21 then gone back retroactively to look to see if
22 any had happened prior to that.

23 And then in going through the
24 process of producing data for these pieces,

1 that's when it was uncovered.

2 But, no, it's the only piece.

3 None of the orders were shipped. It still
4 canceled all the orders. It just was not
5 transmitting the actual suspicious for those
6 individuals.

7 Q. All right. I appreciate that
8 disclosure. We may come back to it. But that's
9 all that I have for now.

10 Okay. So we are literally going
11 to go into lightning round, and I'm going to go
12 through just a scatter shot of the things that
13 we didn't cover previously. If I'm moving too
14 fast, same caveat, or you need context for any
15 of that stuff -- and this is really a test of
16 Natalie and not of you.

17 A. She's passed so far.

18 BY MS. SINGER:

19 Q. All right. I'm trying to find
20 where we left off. Is there a difference
21 between an order of interest and a suspicious
22 order in Cardinal parlance?

23 A. Yes.

24 Q. And what's the difference?

1 A. I would refer to an order of
2 interest as an order when someone in the
3 distribution center wants us to review a
4 specific customer.

5 Q. And how would that get triggered
6 by the distribution center?

7 A. They would reach out either via
8 e-mail or phone call, or they would talk to the
9 compliance officer at the distribution center
10 and do the same thing.

11 Q. Okay. And each distribution
12 center has a compliance officer?

13 A. Yes.

14 Q. And what is their role --

15 A. And I was not including those
16 individuals when I said the 35 people earlier.

17 Q. Okay. And what is the role of the
18 compliance officer in a distribution center
19 distinct from what your team is doing here in
20 Ohio?

21 A. They're responsible for all of the
22 regulatory requirements around the physical
23 security of the controlled substances at the
24 distribution center.

1 Q. Okay. And I know that there's
2 something in the SOPs about these huddles that
3 are done at the distribution center. Is that a
4 concept that you're familiar with?

5 A. I'm familiar with the concept of a
6 huddle. I'm not sure what the specific huddles
7 are that happened at the DCs.

8 Q. Okay. When you say you're
9 familiar with it, from like a football sense --

10 A. Yes.

11 Q. -- or within Cardinal?

12 A. Just a group of people getting
13 together and huddling, yeah.

14 Q. Okay.

15 A. I don't know what takes place in
16 those --

17 Q. Okay.

18 A. -- specifically.

19 Q. And do you know if they still
20 occur?

21 A. I do not.

22 Q. Okay. And are there huddles
23 outside of -- I could have hours with the
24 huddle.

1 A. Well, a lot of teams have daily
2 huddles to go over stuff, yes.

3 Q. Okay. Does your team have a
4 huddle?

5 A. I don't call them huddles, no.
6 No, I don't use that term.

7 Q. Because you're self-respecting.

8 A. I don't use that term.

9 Q. All right. So you're not -- is
10 there any kind of suspicious order related
11 compliance function that happens at the
12 distribution center?

13 A. And that's where the order of
14 interest comes into play, because the DC, the
15 distribution center, cannot exceed the order to
16 pick, pack, and ship it until it has the
17 threshold process on our end.

18 So if they are seeing the order,
19 that means it has cleared through the threshold.
20 So it's basically a second level check that even
21 though it's under the threshold, they have their
22 ability to raise their hand and stop an order
23 and then have us review a customer and ask
24 questions.

1 Q. And how often does that happen?

2 A. It happens frequently.

3 Q. And does that mean once a month,

4 once a week?

5 A. Probably -- definitely monthly.

6 Probably more frequently. It depends on the

7 distribution center, number of customers, number

8 of the types of customers. It varies by DC.

9 But it's a fairly common occurrence to have them
10 ask us to review a customer.

11 Q. And what do they see in the
12 distribution center that triggers that alert?

13 A. They have a different view of the
14 customer, because they get to see a lot of the
15 ordering habits that might be for non-controls.
16 So they, again, can raise their hand at any
17 point and time and stop an order and say, "Hey,
18 I think it's weird that Joe is ordering X. He
19 hasn't ordered that before. Will you take a
20 look at this"?

21 We also use the compliance
22 officers to do surveillance visits on the top
23 controlled substance customers at their
24 distribution centers, too.

1 Q. Okay. And for your investigators,
2 including your compliance officers, when they
3 played that role --

4 A. Yes.

5 Q. -- what kind of background do they
6 have?

7 A. A lot of the -- our investigators
8 have former government investigator and law
9 enforcement background. I'm not sure -- because
10 the COs report into the regulatory compliance
11 arm of QRA, I'm not sure where they've all come
12 from, what their backgrounds are.

13 Q. Okay. And when you say the
14 regulatory compliance side, how is that
15 different from what you do and supervise?

16 A. That would be Linden's structure
17 today. That would include the compliance
18 officers. And it would include the regulatory
19 lawyers that are responsible for making sure
20 that we understand the regs, what they mean, how
21 to interpret them, how to follow them.

22 Q. So is it fair to say that they are
23 the interface with state and federal regulators?

24 A. Yes.

1 Q. From you to them and them to you?

2 A. Yes.

3 Q. Okay. I've covered so much of it.

4 So returning to site visits.

5 A. Yes.

6 Q. They can be requested by QRA,
7 LV TAC, or the ethics and compliance hotline; is
8 that correct?

9 A. Correct.

10 Q. How do those tend to break down in
11 terms of what's triggering a site visit?

12 A. The majority of the site visits
13 are conducted based off of the size of the
14 customer, size of controlled substance, size of
15 opioids, and then the contextual size of the
16 customer, that we have identified here's every
17 customer that is of this size, and we're just
18 going to go do site visits on this customer
19 annually because of the size of the customer.
20 That's probably the majority of them.

21 But, again, to your point, LV TAC
22 could request one. When a new customer comes on
23 board, based on their size, we can do a site
24 visit before we agree to turn a customer on

1 because of the size.

2 Q. Okay. And your QRA team has both
3 pharmacists and data analysts; is that right?

4 A. Yes.

5 Q. And what's -- I think the data
6 analyst is self-explanatory.

7 A. Yes.

8 Q. But what role do your pharmacists
9 play, and how many of them do they have?

10 A. The pharmacists have been very
11 helpful in helping us understand the ancillary
12 prescription medications that go with a specific
13 disease state, as we had mentioned the cancer
14 piece before.

15 So they help us understand if you
16 are supplying a cancer center, here are the
17 anti-secretials, anti-nausea, here are the other
18 drugs we should see.

19 And we spend a lot of time with
20 them focusing on the non-retail class of trades
21 or the long-term care and the hospital business,
22 because it's very different from retail, and you
23 don't have a traditional prescription. You've
24 got patients in beds and types of beds. So

1 they've been very instrumental in helping us
2 build out that methodology.

3 Q. And how many of those folks do you
4 have?

5 A. We have three.

6 Q. And how long have you had them on
7 your staff?

8 A. They've been on staff since I've
9 been in the role.

10 Q. And the ethics and compliance
11 hotline, who does that go to, the complaints
12 that come in through that, or tips?

13 A. Tips or complaints as far as?

14 Q. In general. So if somebody is
15 calling the ethics and compliance hotline --

16 A. Yes.

17 Q. -- who is responsible for
18 monitoring those?

19 A. There's a team of people that are
20 in a specific chunk of compliance. I'm not sure
21 exactly what it's called. That they're the ones
22 that receive the phone calls or the e-mails that
23 come in with whatever issue is raised.

24 Q. Okay. And I take it that's not

1 within your area of supervision?

2 A. No, it's not.

3 Q. Who does that report up to?

4 A. I mean, it ultimately is somewhere
5 under Craig Morford's. I don't know who -- I'm
6 not sure where in the tree that falls from a
7 total high level leadership standpoint.

8 Q. Okay. And have you had
9 information forwarded to you from the compliance
10 hotline?

11 A. I have.

12 Q. What kind of stuff?

13 A. I've had complaints where they
14 have called the hotline on me because I've cut
15 them off or because of threshold reductions.
16 They call and try to get me fired, I think.

17 Q. You wear those with a badge of
18 honor, no doubt.

19 A. Yeah, I guess.

20 Q. How about beyond that --

21 A. No.

22 Q. -- customers complaining?

23 Have there been any former
24 employees, for instance, or current employees

1 who have called in with concerns?

2 A. Not that I'm aware of, no.

3 Q. And do you know how those calls
4 are documented?

5 A. I know that there's an extensive
6 documentation process that they go through,
7 because it's all kinds of -- I think it goes to
8 a third party first, and then it comes into
9 Cardinal online. So there's a third party that
10 manages all of it.

11 Q. Do you know who that third party
12 is?

13 A. I do not.

14 Q. And the decision on whether a site
15 visit is required, who makes that?

16 A. The decision on making a site
17 visit, it's dictated off of the size, the
18 volumes for that specific customer. And then
19 the levels at which we make those visits has
20 been decided by senior leadership; me,
21 previous -- you know, everybody that's -- LV
22 TAC. It's kind of the same concept of the
23 methodology for setting thresholds. It's had
24 multiple people decide on those levels.

1 Q. So beyond those that are
2 automatically triggered because of the size of
3 the customer, the volume of their controls,
4 there are site visits that are triggered by
5 other events?

6 A. Yes.

7 Q. So in deciding with a threshold
8 exceedance or a new customer whether a site
9 visit is required and what kind of site visit is
10 required, who is making that call?

11 A. The parameters of the program
12 would dictate if it was a size visit. If it
13 was -- the analysts are able to request site
14 visits for any customers that they want.

15 To your point earlier about the
16 dispense data customers, we oftentimes will see
17 stuff in there that looks like there's excessive
18 volumes outside of us. They can request a visit
19 for those reasons.

20 If the cash percentage doesn't
21 look right, they can request a visit. The
22 customer could be asking for an increase and
23 they just want to get eyes in the pharmacy and
24 see what's going on. So anyone on the team can

1 request a visit.

2 Q. Okay. So it's an analyst's call
3 unless it triggers one of these other size
4 metrics?

5 A. Unless it falls into a bucket that
6 says you get visited if you look like this.

7 Q. And are you doing any analytics
8 about the proportion of threshold exceedances
9 that involve a site visit or how many site
10 visits your analysts are requesting, for
11 instance?

12 A. Ask me that -- that was a
13 two-parter.

14 Q. I'll break it down. Thank you for
15 keeping me honest.

16 So are you doing any analytics
17 about the number of threshold exceedances that
18 trigger site visits --

19 A. Yes.

20 Q. -- whether that's too high or too
21 low?

22 A. Yes. We're aware of how many
23 visits are taking place because of a threshold
24 event. There's not a too high or a too low

1 metrics, too, which is something we keep track
2 of, because it is one of the factors that can
3 trigger a visit.

4 Q. Okay. And beyond the number of
5 site visits you're doing --

6 A. Yes.

7 Q. -- are you looking at we had
8 20,000 threshold exceedances and only 60 site
9 visits, or 50 percent site visits and --

10 A. So if you go back to how we set
11 the thresholds, and the concept that I know
12 you're tired of hearing of, we're taking that
13 volume of share of the customer. A lot -- the
14 majority of our threshold events are getting
15 driven by customers who we have set at lower
16 levels because of the volume that's coming to us
17 that we are secondary or tertiary. That's
18 driving a lot of the threshold events. So those
19 aren't customers that we're going to be visiting
20 necessarily if our volume is low and we know
21 they're just trying to get an extra 1,000 pills
22 at the end of the month that we're not
23 comfortable distributing because we're in that
24 secondary or tertiary position.

1 So it's not fair to tie the visit
2 piece back to that, because it's just -- it's
3 not going to look right, because so many of the
4 threshold events are driven by the lower volume
5 customers.

6 Q. Okay. How do you know what your
7 distribution position is, whether you're
8 primary, secondary, or tertiary?

9 A. We ask. The sales force knows.

10 Q. How do they know?

11 A. When you go in to call on a
12 customer, you see whose ordering system is
13 behind the counter. You see whose totes are in
14 there. You see whose labels are on the shelf
15 ordering product.

16 Q. Whose "totes"?

17 A. The delivery totes, yeah. So when
18 the product comes, they come in totes, and you
19 see --

20 Q. Not in the public radio sense?

21 A. No, no, no, no. Yeah, you see the
22 delivery boxes from the wholesaler that it comes
23 in.

24 And the pharmacies are usually

1 pretty transparent because they don't want to
2 buy from five people. They buy because it's a
3 commodities market and price drives it. So they
4 would like to buy from one place if price wasn't
5 an issue. So they tell you. We see it in the
6 dispense data. We understand when we do visits
7 we capture the information. We ask point-blank
8 on the visit what percent of controls is coming
9 from which wholesaler.

10 Q. And I take it Cardinal has
11 incentives for people to put you in the primary
12 position?

13 A. The position dictates the costing
14 structure of the product.

15 Q. So is it the case that you either
16 have to order a certain volume or proportion of
17 your sales in order to get more favorable
18 pricing? Is that how that works?

19 A. There are a lot of factors that go
20 into it. I know like, for example, we have a
21 credit department that looks at payment terms
22 and those types of pieces. So a lot of that
23 factors into -- we've got buying groups. A lot
24 of our customers are part of larger buying

1 groups, and that can dictate the deal that goes
2 to the buying group, and those types of things.
3 So there's actually a lot of factors that drive
4 what that price looks like.

5 Q. But is one of the factors the
6 proportion of volume of business that they do
7 with Cardinal?

8 A. It could be in certain instances,
9 yes.

10 Q. Okay.

11 A. Yes.

12 Q. I was struck by one fact in the
13 conversation we've had today in your testimony
14 that so much of the reporting is driven by
15 thresholds but so little of your expectation of
16 what is actually diversion. Is that a fair
17 statement?

18 A. I think so.

19 Q. Okay. Do you all do a training
20 program for your investigators?

21 A. Yes.

22 Q. And is that true for your
23 contracted-out investigators, too?

24 A. Yes.

1 Q. And who's responsible for that?

2 A. The internal investigators I'm
3 responsible for. The third-party from a
4 surveillance visit standpoint runs through
5 Linden and the legal team. And then the
6 third-party full visits I'm responsible for.

7 Q. How many data analysts do you
8 have?

9 A. Tell me what you mean when you say
10 "data analysts."

11 Q. People who aren't pharmacists who
12 do data.

13 A. Ten.

14 Q. And has that been true throughout
15 your tenure?

16 A. We've added a couple since I've
17 been in the role.

18 Q. And just as a general matter, for
19 the things we've talked about, I assume you're
20 answering it for what things are now?

21 A. Yes.

22 Q. Are there things we've talked
23 about that were different when you started in
24 2012?

1 A. I can't think of anything from a
2 conceptual standpoint that we're doing
3 differently than we were. Again, we've got more
4 data. We're seeing things, you know, from a
5 more complete picture. Different drugs have
6 moved around in the hierarchy of things. But,
7 no, it's pretty much consistent conceptually.

8 Q. Okay. Do you know if you have any
9 Montana customers who go through your LV TAC?

10 A. I don't have anyone specific that
11 I can think of that's in Montana, but there very
12 well could be a customer in Montana that meets
13 the volume and ratio requirements, that we would
14 LV TAC them.

15 Q. It's actually a verb?

16 A. Yeah, unfortunately.

17 Q. As long as they're not huddling,
18 that's okay.

19 A. That's right. Trust me, it's not
20 huddling.

21 MS. SINGER: Can we pull MTAG 240.

22 MS. DEYNEKA: Yes, we can.

23 BY MS. SINGER:

24 Q. While Natalie's pulling that,

1 there is a list in your SOPs of things sales
2 reps should look at. And you referred to a long
3 line of people, the not having a lot of other
4 product in the store.

5 A. Yes.

6 Q. Where does that list come from?

7 A. That list was in existence when I
8 came into the role. So I'm not sure what
9 sources that was compiled from.

10 Q. Have you changed at all?

11 A. I don't remember a specific one of
12 those that got changed. But I know that it's
13 looked at periodically to determine if there
14 needs to be -- the verbiage needs to be altered
15 to make more sense or something needs to get
16 added or changed. But, yeah, we can change it
17 if we need to, yes.

18 Q. Okay. But the basic elements
19 remain the same?

20 A. The same, yes.

21 Q. And when a sales rep is doing one
22 of these visits, do you know how long they
23 typically spend on site?

24 A. It would vary depending on how

1 busy, how big the pharmacy is. I would say
2 probably -- now, it would depend if they were
3 solely going to do that or if it was part of
4 doing other things.

5 Q. Let me ask it a different way.

6 A. Yes.

7 Q. How long should the questionnaire
8 of looking for these things, the survey, take?

9 A. Half an hour.

10 Q. And is the expectation that the
11 rep is going to fill out every box?

12 A. Yes.

13 Q. And is there a QC process that if
14 you get one back that has gaps or holes, that
15 that is somehow flagged?

16 A. You can't submit it if you don't
17 answer -- if every box isn't checked.

18 Q. So it's rejected by the system?

19 A. Yes.

20 - - -

21 (Montana-Cardinal Exhibit 13 marked.)

22 - - -

23 Q. Okay. All right. So we're
24 looking at CAH_MTAG_240. This is called

1 "Sales - Anti-Diversion Alert Signals."

2 Is this SOP familiar to you?

3 A. Yes.

4 Q. It's familiar to you?

5 A. Yes.

6 Q. Okay. So one of the things that's
7 added in this policy is that sales reps are
8 performing these assessments or investigations.

9 Do you know why that was added?

10 A. I don't.

11 Q. And does this cover threshold
12 trigger investigations or Know Your Customer or
13 both?

14 A. Both.

15 Q. So one of the flags on Bates
16 number 241 --

17 A. Yes.

18 Q. -- I think it's the fifth bullet,
19 "Pharmacies ordering excessive quantities of a
20 limited variety of controlled substances."

21 A. Yes.

22 Q. You know that from the pharmacies'
23 order data for Cardinal?

24 A. Correct.

1 Q. And what are you looking for
2 there?

3 A. A pharmacy that only orders
4 oxycodone 30-milligram.

5 Q. Okay. And I'm sorry. So this is
6 something the sales rep is looking at, so they
7 must be looking in the pharmacy's own order
8 system; is that right?

9 A. They'd be looking at the orders
10 that would be coming into Cardinal from the
11 pharmacy.

12 Q. Okay. But they're doing this on
13 site at the pharmacy, or is this something
14 they're checking when they get back to the
15 office?

16 A. That piece is probably something
17 that's an ongoing review that they would be
18 doing of each individual customer.

19 Q. Okay. And then moving down, one
20 of the -- the next bullet, "One or more
21 practitioners writing a disproportionate share
22 of the prescriptions for controlled substances
23 being filled."

24 How do you know that?

1 A. That would be part of a
2 conversation that the salesperson would have
3 with the individual pharmacy.

4 Q. Okay.

5 A. A lot of the things that we don't
6 have visibility to, we try to coach the
7 customers into being aware of. And that's what
8 the sales force helps us with.

9 Q. Okay. So there the sales rep is
10 asking the pharmacy "Who are your big
11 prescribers?"

12 A. They're not asking who are the big
13 prescribers. But oftentimes you'll have the
14 pharmacies upset that they're hitting a
15 threshold, and they think they should be able to
16 get more. And we say the threshold is not going
17 to change based on the factors that we see for
18 the pharmacy.

19 The PBC is helping coach the
20 customer on things they can do to then alter
21 their business to live within what we say are
22 normal amounts.

23 Q. Okay. And so how does that play
24 out with respect to this particular factor?

1 A. It would be the PBC talking to the
2 customer and saying, "Hey, you need to take a
3 look at who all your doctors are," and "Do you
4 have doctors that are standing out that are
5 driving these volumes? If so, you need to take
6 a hard look if you should be filing for that
7 doctor or not."

8 Q. All right. And then it moves down
9 to surgery centers.

10 A. Yes.

11 Q. And that is the ambulatory surgery
12 centers about halfway down the page.

13 A. Yes.

14 Q. How do you know how ordering is
15 being handled? Are these, again, customer self
16 reports?

17 A. Yes.

18 Q. Okay. Same with census?

19 A. I'm sorry. Which one are you
20 reading? C?

21 Q. D.

22 A. D. Sorry.

23 Q. "High average daily census."

24 A. Yes.

1 Q. Okay. And then moving down to
2 Physician's Offices.

3 A. Yes.

4 Q. "Is the physician's office
5 excessively purchasing controlled substances?"

6 How do you know what's excessive?

7 A. They'd be having threshold events.

8 Q. Okay. Then number 2 on that page,
9 "If the customer exhibits two or more of the
10 anti-diversion alert signals, then the
11 salesperson is to complete an online survey."

12 In later versions of this policy,
13 that "2" flags is removed?

14 A. Yes.

15 Q. Why was that?

16 A. I believe number 2 is making
17 reference back to one of the previous exhibits
18 that we looked at for the first pharmacy in
19 Montana. And based on how we collect and
20 analyze the data, we now no longer ask customers
21 to complete those surveys. We ask more specific
22 questions around the controlled -- more detailed
23 questions around the dispensing.

24 Q. Okay. So I understand what you

1 are saying.

2 A. Yes.

3 Q. But it sounds like it used to be,
4 that you hit two of these, then there was a
5 deeper reviewed triggered, and then -- is the
6 point not that it's not one or two, but the
7 process that follows?

8 A. Yes.

9 Q. Okay. Now I understand.

10 A. Yes. Exactly.

11 Q. Okay. Then let's move to -- what
12 kind of training do sales reps get ongoing
13 through this process?

14 A. They get trained around kind of
15 some of the pieces we talked about, those
16 obvious signs of diversion that they should be
17 looking for that makes a pharmacy look abnormal
18 from either a volume or ratio perspective.

19 Q. And who provides that training?

20 A. That's done by the training team.
21 And we're involved in creating the training that
22 the training team gives out. But we've got a
23 full-time training team that the PBCs go through
24 ongoing training.

1 Q. I take it there are presentations
2 and scripts and all of that stuff that go with
3 it?

4 A. Yes.

5 Q. So Attachment 1 to this policy is
6 at Bates number 242. And it starts by saying,
7 "We have heard consistent feedback that more
8 tools are needed to perform regular customer
9 data checks."

10 Do you know what that's referring
11 to?

12 A. Yes.

13 Q. What is that referring to?

14 A. It would be the report that it
15 mentions where it gives the sales force the
16 control to non-control view of the customers.

17 Q. Okay. So this was sales reps
18 expressing in a variety of ways that they wanted
19 more guidance and more data? Is that what this
20 means?

21 A. I believe when I look at this,
22 that this is -- this says "Don't distribute
23 externally." I'm not sure if you're allowed to
24 have this.

1 Q. Say that again.

2 A. It says, "Don't distribute
3 externally," so I'm not sure how you have this.

4 I believe that this right here,
5 this page, is making actually reference back to
6 the e-mail you asked me about earlier.

7 Q. Okay.

8 A. That's what the output of that
9 was, which was trying to get information into
10 the sales force's hands to understand what
11 increased levels they should be aware of at the
12 customer level.

13 Q. Okay.

14 A. That's what, I believe, this is
15 making reference to.

16 Q. Okay. All right. And Tom
17 DeGemmis --

18 A. Yes.

19 Q. -- who is he?

20 A. He was the head of the independent
21 sales force at that time.

22 Q. Okay. But he no longer is?

23 A. He is no longer there, no.

24 Q. And who has that role now?

1 A. Steve Lawrence.

2 Q. And the attachment goes on to talk
3 about these highlight reports.

4 A. Yes.

5 Q. Those were discontinued; is that
6 correct?

7 A. I believe they were, yes.

8 Q. And do you know why?

9 A. Not specifically, no. I don't
10 know if then the other components that that
11 e-mail made reference to would be part of that
12 greater IT solution, then came into play, and
13 then these were no longer -- because these were
14 manual reports run on the Sales Operations side
15 for QRA that they were working on a bigger
16 solution.

17 Q. Okay. And this concept of yellow
18 flag, red flag, and watch list, does that still
19 exist within Cardinal in any way?

20 A. The term "red flag" is obviously
21 used in many ways. But as far as how these
22 three pieces are structured, no.

23 Q. Okay. And as I read this, for red
24 flag -- for all three groups, the watch list,

1 yellow flag, and red flag, these were
2 obligations to look at the customer with
3 different levels of urgency?

4 A. Yes.

5 Q. Is that fair?

6 A. Yes.

7 Q. In none of these instances did a
8 customer going on any of these three lists
9 trigger a do not ship requirement; is that
10 correct?

11 A. These would be the sales force
12 specific views use, not reports that QRA was
13 using to make decisions to stop selling to
14 customers.

15 Q. Okay. So that's an entirely
16 different process --

17 A. Yes.

18 Q. -- correct?

19 So a customer being designated red
20 flag or yellow flag didn't trigger any other
21 suspicious order report or do not ship?

22 A. It could have factored into how
23 QRA would set thresholds. I wasn't -- I'm not
24 sure how they on the QRA side used it back then.

1 Q. Okay. All right. But you don't
2 know?

3 A. I do not know, no.

4 Q. All right. Is there a difference
5 between an order that's held and an order that's
6 deleted?

7 A. A held order could be reviewed and
8 potentially released to be shipped. An order
9 that's held and not released gets deleted.

10 Q. Okay. And do you know what
11 proportion of held orders are ultimately deleted
12 versus released?

13 A. I don't know the exact number.

14 Q. Do you know an inexact number?

15 A. I was waiting for you to ask me.

16 Q. I would say probably 90 to
17 95 percent are deleted?

18 A. Are deleted?

19 Q. Yes. Which is why I thought on
20 that spreadsheet we looked at, the 323 versus
21 289, was probably the delta.

22 MS. SINGER: Do you have the rest
23 of the report that goes with 253?

24

1 BY MS. SINGER:

2 Q. While Natalie is responding to my
3 ever changing requests, we can go to another
4 one.

5 So the SOP seems to make clear
6 that when an order exceeds the threshold limit
7 for a drug family, subsequent orders from the
8 same drug family are held.

9 A. Yes.

10 Q. That's correct?

11 A. Yes.

12 Q. And that's still Cardinal's
13 policy?

14 A. Yes.

15 Q. So we read that to say that if you
16 exceed threshold on oxycodone, you can still
17 purchase and get shipped hydrocodone?

18 A. All the thresholds are at the DEA
19 base code level, and they're all independent of
20 each other.

21 Q. Okay. So why would a pharmacy's
22 orders of oxycodone be suspicious and not its
23 orders of hydrocodone?

24 A. Again, because we are setting

1 those thresholds at each individual base code
2 level. And they're not the same drugs, so they
3 would have different thresholds.

4 Q. All right. But when you're
5 looking at this from a customer perspective --

6 A. Yes.

7 Q. -- is it likely that a pharmacy is
8 diverting hydrocodone and not oxycodone?

9 A. I don't know.

10 Q. Are you aware of that happening?

11 A. I know that I've seen instances
12 where DEA has gone after pharmacies for one of
13 those drugs and not the other.

14 Q. Okay. And are you aware in
15 Cardinal's experience of a pharmacy that was
16 diverting one opioid and not another?

17 A. Yes.

18 Q. So give me an example.

19 A. We've seen pharmacies that were
20 doing oxycodone, high volumes of it in
21 proportion to the size of the pharmacy, most of
22 it 30-milligram, for example, and weren't doing
23 any hydrocodone.

24 Q. So would your response be to

1 terminate that customer or continue to supply
2 them with hydrocodone because they weren't
3 diverting that?

4 A. No. We would terminate them for
5 all controls and cut them off.

6 Q. But that's not what this policy
7 says. This policy says you can continue to ship
8 the other drug family.

9 A. You're talking about threshold
10 events or cutting a customer off?

11 Q. I'm talking about for the
12 threshold events.

13 A. Yeah. That makes -- they're not
14 cutting them off. Just they've reached their
15 threshold.

16 Q. So they've reached their threshold
17 on oxycodone?

18 A. Yes.

19 Q. And you're comfortable continuing
20 to ship them hydrocodone or fentanyl as long as
21 that's within those base code thresholds?

22 A. Yes.

23 Q. And then when the next threshold
24 period resets, they get to start over again?

1 A. Yes.

2 Q. And they're shipping oxycodone
3 again?

4 A. Yes.

5 Q. Okay. And do you look from a
6 compliance perspective at pharmacies that
7 continue to hit threshold month after month?

8 A. Yes.

9 Q. And in how many instances are you
10 then terminating the customer versus increasing
11 the threshold?

12 A. It would depend on the individual
13 customer and specifically in our distribution
14 position. So if you had a very low threshold
15 and we were supplying you 5,000 of your 30,000,
16 and we were okay with the 30,000, then we would
17 continue to cut the orders of 5,000 and report
18 them.

19 It again goes back to we're going
20 to ensure that the volume we distribute for the
21 share of that customer we have are going to make
22 sense analytically, which leads to a lot of
23 threshold events, which is why I say a lot of
24 threshold events comes from the lower volume

1 customers.

2 Q. So it sounds like from what you're
3 saying then, in the vast majority of the cases,
4 threshold exceedances will not lead to
5 termination of a customer, and either you will
6 override the threshold increase, there's nothing
7 there, or you'll increase the threshold?

8 A. Those are two outcomes that could
9 happen, yes.

10 Q. But it sounds like those are also
11 the most frequent outcomes?

12 A. The most frequent is to cancel and
13 report the order. That's the most frequent.

14 Q. And then the order could be
15 shipped next month.

16 A. Once it resets, yes. In the next
17 time frame.

18 Q. Okay. And so what I'm trying to
19 get at is, in that pattern of exceedances and
20 then shipped next months?

21 A. Yes.

22 Q. In most of those case when you
23 look at that customer's order data --

24 A. Yes.

1 Q. -- you're going to continue to
2 supply that customer?

3 A. It would depend. If the total
4 dispensing of the pharmacy was within normal
5 acceptable ranges and we were just in a
6 secondary or tertiary position versus we weren't
7 comfortable with the customer's total
8 dispensings, in that case we would cut them off.

9 Q. So I completely hear what you're
10 saying on the policy side. I'm just wondering
11 about the pure -- the pure metrics of it.

12 A. Yep.

13 Q. So in most cases, that customer is
14 going to continue to be a customer receiving
15 orders over time?

16 A. Yes.

17 Q. And in a small fraction of those
18 cases, you're going to terminate the customer?

19 A. I don't know if I want to say
20 small fraction. But, yes, the majority of the
21 time, again depending on the individual customer
22 and the position we're in in the supply chain,
23 that will determine if we continue to supply
24 them or not.

1 - - -

2 (Montana-Cardinal Exhibit 14 marked.)

3 - - -

4 Q. So Exhibit 14 is -- CAH_MTAG_1614
5 is the Bates number.

6 A. Yes.

7 Q. And I want you to look at Bates
8 number 1618.

9 A. Okay.

10 Q. And, by the way, is this SOP on
11 cage/vault suspicious order monitoring familiar
12 to you?

13 A. It is not. This would be part of
14 the compliance officer side of things because
15 it's in the distribution centers, the security
16 cage and vault.

17 Q. All right. Number 8 on Bates
18 number 1618 indicates about halfway through,
19 "Notification does not apply to national chain
20 accounts."

21 And you can take a minute and read
22 the context. But why are chain accounts treated
23 differently?

24 A. So, again, this is not -- there's

1 your huddle on there.

2 Q. Thanks.

3 A. Yeah. So this is not my area. So
4 I am giving you my best interpretation of this.
5 But I would assume that the communication would
6 take place directly with the corporate office of
7 the national account as opposed to trying to
8 communicate and get information straight from
9 the individual pharmacy.

10 Q. You referred earlier to that
11 survey that was no longer being done.

12 A. Yes.

13 Q. Do you know why that was
14 discontinued?

15 A. The level at which the questions
16 were asked in the survey versus how we ask
17 questions today around a specific drug family,
18 we get into much more detailed questioning at
19 the customer level.

20 That survey was -- when you first
21 read it, it almost looked like it was a KYC. It
22 wasn't getting into specific drug issues. So
23 that was at that point in time sent as part of a
24 threshold. Now is the threshold where we're

1 reaching out and asking about the specific drug
2 family, the strength. So there's just a much
3 more detailed conversation that takes place
4 today that if it were in the form of a survey,
5 it would be 50 pages.

6 Q. Okay. And when you say KYC, I
7 assume you mean Know Your Customer?

8 A. I'm sorry. Yes. Know Your
9 Customer, yes.

10 Q. Okay. Can customers initiate a
11 threshold increase? Can a customer request?
12 Yes?

13 A. Yes.

14 Q. Okay. And is there a formal
15 process that they have to submit something, or
16 how does that work?

17 A. They're supposed to go through
18 their sales consultant. Because, again, that's
19 where a lot of PBCs want the sales consultant
20 involved in the evaluation of the business so
21 they're not asking for stuff that they know
22 we're going to say no to, and we expect them to
23 be involved in asking a lot of these questions
24 and knowing the customer on their side. So we

1 don't have a formal process for the customer to
2 reach out directly to us. It comes in through
3 the PBC.

4 Q. And either for a
5 customer-initiated request or your own
6 evaluation, do you know how many reviews end up
7 in an actual increase in threshold versus how
8 many are rejected?

9 A. I don't, other than to say the
10 requests that are made for customers whose
11 volumes make sense within the context and
12 they're within the methodology, that we don't
13 see any concerns from diversion of those would
14 get increased.

15 Q. And is that the majority of cases?

16 A. I can't say either direction,
17 because oftentimes you'll have -- like we talked
18 about, a secondary customer that wants more,
19 that we're not going to move the threshold
20 because we're in a secondary position.

21 Q. Okay. And when you're the
22 primary, is that typically going to go through?

23 A. It would depend on if they're
24 within methodology based on those factors. But

1 if you are within methodology, from a review
2 standpoint, then those typically would get
3 approved.

4 Q. And have you done any analysis of
5 how many customers have had their threshold
6 increased since 2012?

7 A. Not since 2012.

8 Q. And what baseline have you looked
9 at?

10 A. We look at how many thresholds
11 that we change and how many went up and how many
12 went down.

13 Q. And for what time period did you
14 do that?

15 A. We've been looking at that for the
16 last probably couple years.

17 Q. And you do that on an annual
18 basis?

19 A. Quarterly.

20 Q. Quarterly?

21 A. Yes.

22 Q. And what has been the conclusion?

23 A. There hasn't been any conclusion,
24 because you've got so many customers that are

1 primary, secondary, tertiary, moving from
2 secondary to tertiary, moving from tertiary to
3 primary, new business, business that left, that
4 you're not looking at it from a same store sales
5 perspective to say it was a consistent customer
6 base. You've got so many movement factors
7 within it, that you can't necessarily at the
8 high level draw any conclusions from it.

9 I know that doesn't answer your
10 question. I'm sorry. It's just there's too
11 many moving pieces at that level to make a
12 determination.

13 Q. Okay. And have you ever looked at
14 how many orders that are cut or denied in a
15 month or subsequently filled the next month?

16 A. No.

17 Q. Are there a suite or a set of
18 reports that you get every day or every month or
19 every quarter?

20 A. There are data analytic pieces
21 that I would get on a monthly or quarterly
22 bases, yes.

23 Q. Are we going to have this same
24 debate?

1 A. I can't tell. It's up to you.

2 That's why I was hesitating. I was trying not
3 to force you into that.

4 Q. Okay. And so you are getting this
5 information. It may not come in a title passed
6 on to your desk report?

7 A. Yes.

8 Q. And who provides it to you?

9 A. It could come from the analytics
10 group. It could come from somebody on the
11 customer facing team. It could be something
12 that I do myself.

13 Q. Okay. And is there kind of a set
14 that your staff knows you want to see something
15 on a regular basis, or how does that work?

16 A. You know, there are certain
17 components. One example would have been that
18 gap report that we talked about earlier. That's
19 something that I like to review that they know I
20 want to see after they make the changes.

21 Q. And are there other things like
22 that that come to your mind?

23 A. I review all the investigative
24 site visits after they happen, as an example.

1 Q. Okay.

2 A. Those are the common ones.

3 Q. Okay. That's not the one that you
4 have 40,000?

5 A. No, it's not. No.

6 Q. Which set of reports are those?

7 A. It's the, as you put it, look
8 under the hood ones. It's those.

9 Q. Okay.

10 A. Now, I do see all the ones that
11 have a yes answer.

12 Q. And how many are there of those?

13 A. Very small percentage.

14 Q. Okay. Do you have a rough
15 estimate?

16 A. Less than 1 percent.

17 Q. Are there reports that you owe to
18 your supervisors?

19 A. There are metrics that we create
20 that we look at, yes.

21 Q. And how often do you do that?

22 A. Most of them are quarterly.

23 Q. Okay. And do you do an annual
24 report to them, including in the form of your

1 own self evaluation?

2 A. Yes.

3 Q. Okay. And is that where those
4 metrics are reflected in your annual self
5 review?

6 A. The metrics would not be part of
7 my self review, for example.

8 Q. Okay. But there is a quarterly
9 and annual --

10 A. Yes.

11 Q. -- process that you go through?

12 A. Yes.

13 Q. Have you been involved in any
14 reporting to Cardinal's board?

15 A. Yes.

16 Q. And when and what has that been?

17 A. It's been kind of presenting the
18 program to the board of how we're doing, what
19 we're doing, why we're doing it the way that
20 we're doing it.

21 Q. And are those reports or metrics?

22 A. They're PowerPoints.

23 Q. Okay.

24 A. And I know that there are other

1 board discussions around certain pieces of this
2 that I'm not a part of.

3 Q. Okay. And how many reports to
4 Cardinal's board have you done?

5 A. Thirty.

6 Q. Okay. And those took the form of
7 PowerPoints?

8 A. Yes, or discussions.

9 Q. Okay. And have those been to the
10 full board or to a committee of the board?

11 A. Both. There's a subcommittee and
12 then a board.

13 Q. And what's the subcommittee
14 called?

15 A. I'm not sure. I'm not sure what
16 the specific name is.

17 Q. Okay. And have you ever had board
18 members reach out to you with questions or
19 concerns?

20 A. Not outside of those formal
21 meetings.

22 Q. When did those meetings happen?

23 A. We had one recently. And then
24 another one was probably the year before.

1 Q. And what concerns did the board
2 raise and what questions in the context of those
3 discussions?

4 MS. WICHT: Todd, I'm going to
5 interject. I don't have any -- I don't
6 have any reason to understand that those
7 were privileged. But I just raise that
8 for you in case for some reason you're
9 aware of it.

10 A. Just a lot of questions around the
11 trends; you know, is prescribing going up, is it
12 going down, what does the customer base look
13 like, you know, whose -- questions around other
14 wholesalers and programs and things like that.

15 Q. And are those conversations
16 reflected in board minutes?

17 A. I don't know.

18 Q. Have you ever seen any minutes of
19 those discussions?

20 A. No. I only get to be there for my
21 little part, and they kick me out.

22 Q. And have there been any concerns
23 raised about Cardinal's program?

24 A. Not that I'm aware of, no.

1 Q. Have there been any discussions
2 with the board about DEA authority or
3 enforcement or DEA concerns about Cardinal's
4 compliance program that you've been involved in?

5 A. Can you ask me that again?

6 Q. So I'll break it down. Have you
7 had any discussions with the board about the
8 nature or content or trajectory of DEA's
9 enforcement or inspections of Cardinal?

10 A. No. Now, I know that there are
11 discussions around the cyclic inspections that
12 take place with DEA and the distribution center,
13 but I wouldn't have spoken to that.

14 Q. Okay. Your focus in terms of
15 particular opioids as it's evolved, has it been
16 focused on pills, or have you seen diversion
17 with specific forms, meaning the cough syrups
18 or ...

19 A. ProMeth with codeine is something
20 that we monitor and have thresholds for and have
21 customers off because of.

22 Q. And any other drugs that come to
23 mind?

24 A. Yeah. I mean, we're looking at

1 morphine and methadone and hydromorphone and
2 oxymorphone and all of those drugs. And there's
3 liquid forms of those.

4 Q. Large volume customers, is there a
5 numeric cutoff for that?

6 A. Yes.

7 Q. Do you know what it is?

8 A. I don't, because there's multiple
9 factors that play into it. It can be a fixed
10 volume amount. It can be a volume amount based
11 off the size of the customer, or it can be a
12 volume amount within the mixes within the volume
13 of that specific control.

14 Q. And where are those criteria
15 reflected?

16 A. They're definitely written down,
17 documented.

18 Q. A guideline?

19 A. I don't know if it's in a
20 guideline, but there's customer segmentation
21 definitions for sure.

22 Q. Okay. And LV TAC, how often does
23 it meet?

24 A. Once a month.

1 Q. And you're part of that group?

2 A. I am.

3 Q. And who are the other key players?

4 A. Regulatory counsel is involved in
5 that. The compliance officer could be
6 potentially involved if they've got some
7 knowledge of the customer, and then the
8 directors on my team.

9 Q. And are there particular customers
10 who are teed up for discussion?

11 A. Yes.

12 Q. And is there an agenda?

13 A. I wouldn't call it an agenda. But
14 there's a list of customers. And then all the
15 datasets around the customer that we review.

16 Q. And those are circulated to the
17 members by e-mail?

18 A. The components we review live in
19 the meeting. The meetings are several hours
20 long. So the components don't get sent around
21 because the files are huge. But the list of the
22 customers is distributed ahead of time.

23 Q. Okay. And who's the person who
24 administers that process, of circulating the

1 agenda and --

2 A. Various individuals on my team do.

3 Q. Like? Can you give me names?

4 A. It varies on the team. Do you
5 want multiple names?

6 Q. Yes.

7 A. Dani Roberts would be one. Kim
8 Howenstein would be another.

9 Q. Okay. And are there minutes or
10 follow-up e-mails that go out after those
11 minutes?

12 A. There are memos that are created
13 for customer review.

14 Q. Okay. "DEA Limit Over Threshold
15 Report," is that the report that generates
16 suspicious order reports for DEA?

17 A. I'm not sure what that is based on
18 that name.

19 Q. Okay. So that name is not
20 familiar to you?

21 A. That name is not familiar.

22 Q. Okay.

23 A. I would assume that it was the
24 algorithm report based on the way it sounds.

1 But I don't know that for sure.

2 Q. Okay. You mentioned earlier while
3 Natalie was looking for those documents that
4 you'd look at a customer's business model.

5 A. Yes.

6 Q. What are you looking for?

7 A. Is it a retail pharmacy, is it a
8 hospital, is it an institutional retail
9 pharmacy, is it a long-term care, is it mail
10 order.

11 Q. Okay. In January of 2013, you
12 implemented a new threshold setting methodology
13 that used the pharmacy's prescription count?

14 A. Yes.

15 Q. Do you remember what was different
16 about that and why you introduced it?

17 A. That was the concept of trying to
18 take the total contextual size of the pharmacy
19 and use that size to translate it into a
20 threshold for controlled substances.

21 Q. Okay.

22 A. Back to my 1,000-script-a-day
23 pharmacy would do more oxycodone than
24 100-script-a-day pharmacy.

1 - - -

2 (Montana-Cardinal Exhibit 15 marked.)

3 - - -

4 Q. All right. So this is CAH_MTAG

5 Bates Number 1161.

6 So is that document familiar? And

7 if you could, read the title of it, please.

8 A. "Daily Threshold Reporting."

9 Q. So on page 1164 of that --

10 A. Yes.

11 Q. -- it has a reference to that

12 report I mentioned, the over -- if you could say

13 the name.

14 A. The daily threshold reporting?

15 Q. Yes. Does that give you any other
16 clues about what that's referring to?

17 A. So what is on page 1164?

18 Q. Yes. It's Number 2, "E-mail
19 modified daily."

20 A. Yeah. I'm assuming --

21 Q. And you're on the distribution
22 list?

23 A. I am. I'm going to read this real
24 quick. Sorry.

1 So I'm assuming this is the report
2 that would have been created notifying people of
3 the threshold events that happened.

4 Q. Okay.

5 A. So basically an e-mail of all the
6 held orders.

7 Q. Okay. And those are sent out
8 every day?

9 A. Yes.

10 Q. And it doesn't sound like this is
11 a critical report in your mind, so you couldn't
12 remember it. But do you know what people are
13 looking for in that report or if they are using
14 it?

15 A. I don't know if it's used or for
16 what exactly, but the concept of it is to let
17 people know that a specific pharmacy had their
18 order canceled or reported as suspicious in case
19 a customer calls and says, "Hey, I didn't get my
20 order. What happened?"

21 Q. So this goes to the sales side as
22 well?

23 A. Yes. Exactly.

24 Q. And then Bates Number 1165 has an

1 attachment that is the anti-diversion customer
2 profile. Is this familiar to you?

3 A. This specific view of it is not,
4 but components within it are familiar to me.

5 Q. Okay. So in hopes of finding some
6 of those. "Total Number of Events" at the
7 bottom of the first column --

8 A. Yes.

9 Q. -- do you know what that
10 represents?

11 A. I assume that represents number of
12 thresholds.

13 Q. Okay. And "QRA Restriction"?

14 A. I would assume that would be a
15 customer has been cut off, but I'm not sure.

16 Q. I'm sorry. I missed that.

17 A. It might be that the customer had
18 been cut off, but I'm not sure.

19 Q. Okay. And then on the second
20 column, "Percentage Order Quantity Above
21 Average"?

22 A. I'm not sure. This wasn't
23 something that was part of the e-mail that we
24 just talked about. This is an internal QRA

1 document --

2 Q. Okay.

3 A. -- that was back from 2008.

4 Q. So it's not currently used?

5 A. No.

6 Q. Okay.

7 A. No.

8 - - -

9 (Montana-Cardinal Exhibit 16 marked.)

10 - - -

11 Q. So I just wanted to ask you about
12 the dialogue.

13 A. Yes.

14 Q. So it indicates that threshold
15 should not be shared with the customer.

16 A. That's what -- yes, I read that
17 here.

18 Q. Okay. Is that still the policy?

19 A. No.

20 Q. And why was it and why isn't it?

21 A. I don't know why it was back at
22 that point in time. But today our philosophy is
23 we want the customers to understand our review
24 of them and how they look, especially compared

1 to their peers, and if we need them to -- some
2 of the questions you saw earlier about taking a
3 look at their own business and the doctors that
4 are filling for them, they can understand why
5 we're asking them to do so.

6 Q. And I know we talked about you not
7 having heard concerns about structuring or
8 things like that, but presumably the earlier
9 concern is that customers would try to
10 manipulate threshold and fly under the radar
11 screen. Is that not something that concerns
12 you?

13 A. The way the system is designed
14 today -- again, taking what you're buying from
15 us in totality and then converting that into an
16 acceptable share of controlled substances,
17 that's why we do it the way that we do so the
18 customers can't gain the system.

19 That's why we have so many
20 threshold events because they're trying to buy
21 what is their normal total volume of controls
22 from us, and we won't let them have it because
23 we're only getting a smaller share. That's what
24 leads to some many threshold events. That's how

1 we keep them from gaining it.

2 Q. So we talked about the fact that
3 in some instances, you'll notify DEA when a
4 customer is terminated.

5 A. Yes.

6 Q. Will you notify DEA if you resume
7 sales to that customer?

8 A. Yes.

9 Q. What?

10 A. Yes.

11 Q. Why do you smile when you answer
12 that?

13 A. Do you really think if we cut
14 somebody off and tell DEA, we'd ever turn them
15 back on again?

16 Q. You don't?

17 A. We never have, no. That's
18 probably asking for trouble.

19 Q. That's the point.

20 A. Once you tell DEA, then ...

21 Q. Okay.

22 MS. WICHT: So your answer was
23 hypothetically if we ever did that, we
24 would tell DEA?

1 THE WITNESS: Yes, yes.

2 BY MS. SINGER:

3 Q. Okay. But you certainly restore
4 customers you've terminated?

5 A. We do.

6 Q. Yes? But you don't tell DEA when
7 that happens because --

8 A. No. I'm saying if we were to tell
9 DEA that we cut somebody off, we would probably
10 never turn you back on.

11 Q. So you don't report in the first
12 instance?

13 A. No. We would report. We would
14 just never change our mind.

15 Q. So the only customers you would
16 restore are customers you hadn't reported to
17 DEA?

18 A. I'm just saying if you tell DEA
19 you cut somebody off, you better be darn certain
20 before you turn them back on. We would err on
21 the side of the conservatism and just never turn
22 them back on.

23 Q. Okay. So if you do turn them back
24 on, you didn't report them to DEA in the first

1 place, so you're not going to tell DEA you've
2 restored them?

3 A. It would be in a state that we're
4 not asked by DEA to tell them. That's what
5 determines if we tell them or not.

6 Q. Okay. Okay.

7 A. If DEA wants us to tell them, we
8 tell them.

9 Q. And then they're done?

10 A. That would probably be a safe
11 assumption, yes.

12 - - -

13 (Montana-Cardinal Exhibit 17 marked.)

14 - - -

15 Q. All right. So Exhibit 17 starts
16 at CAH_MTAG_898.

17 A. Yes.

18 Q. And I just want to turn your
19 attention to 902.

20 A. Okay.

21 Q. Is that what a suspicious order
22 report looks like?

23 A. I do not believe so.

24 Q. Is that document familiar to you?

1 A. When I look at this, I assume this
2 is something that existed with the DEA field
3 office specific. But the suspicious orders that
4 we report go to corporate headquarters. And I
5 believe --

6 Q. Meaning DEA headquarters?

7 A. Yes. Sorry. DEA headquarters.
8 And I believe the data -- I think it's kind of
9 similar to how ARCOS data goes. It's a series
10 of information that I don't think -- it doesn't
11 look like this.

12 Q. Okay. Meaning it's not a single
13 order --

14 A. No.

15 Q. -- that you're reporting? You're
16 reporting a group?

17 A. Yes. Exactly.

18 Q. Okay. And then --

19 A. And I would guess that, for
20 example, if these were the seven components,
21 which I don't think they are, they'd be in one
22 row.

23 Q. Okay. And then if you could look
24 at 905 as well. I'm assuming that the answer is

1 going to be the same, that that's not a
2 report -- that's not a notice you use anymore;
3 is that correct?

4 A. Yeah. And I don't know if it ever
5 was used. I'm not familiar with this -- with
6 either of those two pieces.

7 Q. Okay. Earlier you talked about
8 the fact that some -- you know, that phone
9 conversations, for instance, between a sales rep
10 and a customer wouldn't be reflected in their
11 profile.

12 Does Cardinal record its lines?

13 A. Not that I'm aware of.

14 Q. Okay. Even for sales reps
15 reaching out to solicit customers, none of that
16 is on recorded lines, to your knowledge?

17 A. Not that I'm aware of.

18 - - -

19 (Montana-Cardinal Exhibit 18 marked.)

20 - - -

21 Q. So if you could just recite the
22 Bates number at the bottom.

23 A. CAH_MTAG_0001106.

24 Q. That may be the -- can you turn it

1 around? What's the first page? Yes. Read the
2 Bates number on the first page?

3 A. Oh, sorry. CAH_MTAG_0001101.

4 Q. All right. So we'll look at it in
5 that direction.

6 A. Okay.

7 Q. So on 1103 --

8 A. Yes.

9 Q. -- it indicates that
10 "Unintentional order entry errors must be
11 reported to DEA as suspicious."

12 MS. WICHT: I'm sorry. Which
13 page?

14 MS. SINGER: 1103.

15 A. Which number are you looking at?

16 Q. I don't know.

17 A. Okay. I'll find it. I got it.

18 Okay.

19 Q. The number -- what number is it?

20 A. I believe it's 6.1.5.2.

21 Q. Yes, 6.1.5.2. Why is it that
22 Cardinal would report unintentional order entry
23 errors?

24 A. When an order comes in that hits

1 the threshold that we do not have the necessary
2 information appropriate to release the order, we
3 cancel and report the order.

4 Q. Okay.

5 A. So if you accidentally entered a
6 higher number -- I mean, that's a great answer.
7 I think we probably get that answer a lot. "Oh,
8 I didn't mean enter it. I didn't mean to order
9 that." So we can't decipher between what hits
10 the threshold, and we don't release it. We cut
11 and report it.

12 Q. Okay. And then 1104, 6.1.7.1.

13 And, by the way, before I ask you
14 that specifically, is this an SOP that you're
15 familiar with?

16 A. Yes.

17 Q. It is? Is it still used by
18 Cardinal?

19 A. I've got to be careful how I
20 answer that because it has my name on it.

21 Q. I assume you're careful about
22 every answer you've given.

23 A. I believe this is the most current
24 version of this specific SOP. But I'm not

1 100 percent positive there's not a more current
2 version.

3 Q. All right. So let's look at
4 6.1.7.1. It talks about what a deviation and an
5 ordering pattern includes.

6 A. Yes.

7 Q. So for a, b, c, and d, it lists
8 different factors. Do you have numeric metrics
9 that go along with these to determine, for
10 instance, what an unusually high percentage of
11 controlled substances are?

12 A. Yes.

13 Q. And same is true for each of
14 these, unusually high percentage of particular
15 strength?

16 A. Yes.

17 Q. And cumulatively larger than
18 expected for the customer?

19 A. Yes.

20 Q. And then other deviations is
21 obviously a subjective element?

22 A. Yes.

23 Q. Okay. And then looking at 6.2.1.
24 What is a held order that warrants assessment as

1 opposed to a held order?

2 A. It would be -- so a held order
3 that warrants assessment to the threshold as
4 opposed to held order that does not warrant
5 threshold change that you're just going to
6 report as suspicious and not review to make
7 changes.

8 Q. So that's what you talked about
9 earlier. It's an analyst's judgment, unless it
10 hits some of those other triggers?

11 A. Yes.

12 Q. So 1105 talks about "If the
13 decision is to retain the customer," it says,
14 you will continue to monitor the customer.

15 What does that involve?

16 A. It would go back to that monthly
17 assessment of what all of the objective factors
18 look like for that specific customer and to
19 determine -- to some of your questions earlier,
20 they may not get terminated that month, but two
21 or three months later, if things haven't
22 changed, then they could be cut off.

23 Q. So it's not like Cardinal has a
24 watch list? It's that if this customer surfaces

1 in other data reviews you're doing?

2 A. Yes, yes.

3 Q. Okay.

4 - - -

5 (Montana-Cardinal Exhibit 19 marked.)

6 - - -

7 Q. Exhibit 19 is titled "Attention.
8 Health Pending Regulatory Review." It's Bates
9 Number CAH_MTAG_1438.

10 Is that familiar to you?

11 A. I've got 1417.

12 Q. Sorry. Let's sub in, and we'll
13 just --

14 MS. WICHT: What number are we
15 supposed to have? Sorry.

16 THE WITNESS: 1438.

17 MS. SINGER: It's the same
18 document.

19 MS. WICHT: Okay.

20 BY MS. SINGER:

21 Q. So it can either be 1417 or --
22 what did you say the other Bates number is?

23 A. 1438.

24 MS. WICHT: I have 1499. Just

1 want to make sure I have the right
2 thing. That's all. That actually does
3 look a little bit different.

4 Thank you. I appreciate it.

5 BY MS. SINGER:

6 Q. Is that familiar to you?

7 A. It is not. I think I know what it
8 is.

9 Q. What is it?

10 A. It looks like something that would
11 go in the customer's tote, the delivery box, not
12 the other, when an order was held. When a
13 threshold event occurred, this looks like what
14 would show up in lieu of the product.

15 Q. Okay. So that's handled by the
16 distribution center?

17 A. Yes.

18 Q. I'm going to try to do some of
19 these without pulling documents. If you need to
20 see them, just ask.

21 A. Okay.

22 Q. So one of the things that your
23 Know Your Customer questionnaire asks is what
24 the customer's demographics are.

1 Do you know what that means?

2 A. Do you know how old that KYC is,
3 by any chance?

4 Q. I'll know in a second.

5 While Natalie is pulling that, how
6 often do you all decline new customers who are
7 brought to you?

8 A. It goes in waves based on kind of
9 what's happening in the industry.

10 Q. Meaning McKesson has a
11 distribution center shut down, you may see a lot
12 more new customers?

13 A. Yes. And we may decline more
14 customers at that point in time, yes.

15 Q. So it's a cyclical process?

16 A. Yeah. I mean, we are always
17 reviewing and potentially denying customers,
18 but, you know -- Morris & Dickson had a
19 suspension recently, and we had a higher rate of
20 denials during that period of time, for example.

21 Q. And to approve a new customer, is
22 there a level of sign-off required?

23 A. Yes.

24 Q. At what level?

1 A. It's very similar to the threshold
2 approval piece, that it could potentially have
3 to go in front of LV TAC to get approved.

4 Q. And what about when a customer is
5 rejected? Is there any upper level sign-off
6 that's needed on that?

7 A. No. If they don't pass the
8 metrics, then they get denied. You could pass
9 the metrics but the volume is high enough that
10 we still want to put those in LV TAC.

11 - - -

12 (Montana-Cardinal Exhibit 20 marked.)

13 - - -

14 Q. So Exhibit 20 is Bates Number 316.
15 And this is to allow you to see the customer
16 demographics, which is at 319, 6.3.2a.

17 A. Thank you. So I don't know if
18 customer demographics is name, city, state, Zip.
19 I'm not sure what they mean by demographics
20 there.

21 Q. So that's not something that you
22 use in your evaluation?

23 A. No.

24 Q. Is a customer that's rejected

1 logged in your system in some way?

2 A. Yes.

3 Q. So you could pull out every
4 Montana pharmacy that sought to be a customer
5 and was rejected?

6 A. Yes.

7 Q. And you were going to qualify
8 something?

9 A. I was just going to say that there
10 are times when we would do a perspective review
11 of a customer that we might not know who the
12 customer is to be able to know that.

13 Q. Okay. And when you take on a new
14 customer, what effort do you make to find out
15 who was distributing to them before?

16 A. We ask at that point in time.

17 Q. You ask the customer?

18 A. Yes.

19 Q. And you rely --

20 A. Yes.

21 Q. -- on the customer's word?

22 A. Yes.

23 Q. And I presume that you ask the
24 customer why they're in the market for a new

1 distributor?

2 A. Yes. Ask me the next question.

3 Q. What?

4 A. Do you want to ask the next
5 question?

6 Q. Go ahead. What's the next --

7 A. How often do they say that they
8 were cut off? Not very often.

9 MS. WICHT: Cameron, don't do
10 that.

11 Q. How often do they say they were
12 terminated?

13 A. Not very often, which is why --

14 Q. How often should they say they
15 were terminated?

16 A. Again, that's why we set
17 thresholds the way that we do, so when you come
18 on board, even if the KYC is not filled out
19 accurately, we're going to be converting those
20 purchases into scripts and convert those into
21 thresholds. So it's going to protect us right
22 out of the gate on how those thresholds are
23 calculated.

24 - - -

1 (Montana-Cardinal Exhibit 21 marked.)

2 - - -

3 Q. So this is Bates number

4 CAH_MTAG_214.

5 A. Thank you.

6 Q. So this is a retired policy

7 related to national chain accounts, correct?

8 A. Correct.

9 Q. And there was a period of time
10 when Cardinal excluded chain accounts from its
11 Know Your Customer requirements; is that
12 accurate?

13 A. I know that there are components
14 of the KYC that are completed by the national
15 accounts team for national accounts.

16 Q. Okay. But not the full Know Your
17 Customer diligence process? You said components
18 that are --

19 A. From the KYC. So a lot of the
20 components when the customer comes on board to
21 fill out the information for national accounts,
22 that gets done by the national accounts team
23 because there's a corporate office that would be
24 involved in the completion in answering those

1 questions.

2 We still set the thresholds.

3 They're not involved in that process. But as
4 far as the documenting of the KYC for the
5 national accounts, that's done by that team.

6 Q. So my understanding is that
7 national chain accounts are treated differently
8 on the -- because of the assumption that they
9 have their own anti-diversion programs. Is that
10 accurate?

11 A. Treated differently in what way?

12 Q. They aren't subject to the same
13 kind of Know Your Customer onboarding as
14 independents.

15 A. That is true.

16 Q. And does Cardinal make any effort
17 to audit or check a chain pharmacy's
18 anti-diversion program?

19 A. The benefit to the national
20 accounts is we get corporate level --
21 corporate-provided store level data. And those
22 national accounts buy all of their controls from
23 us. So we actually have a better picture of the
24 national chains because they're not buying from

1 four or five wholesalers like independents are.

2 So I would say we actually have more scrutiny on
3 the chains than we do the independents.

4 Q. Okay. Because they give you more
5 data?

6 A. Yes.

7 Q. And because you're the only
8 distributor?

9 A. Exactly.

10 Q. And -- okay. So understanding
11 that that gives you a confidence level --

12 A. Yes.

13 Q. -- do you all do any examination
14 of their own anti-diversion programs?

15 A. No.

16 Q. And has it always been the case
17 that chains have given you this corporate level
18 data for all of the pharmacies you supply?

19 A. Since I've been in the role.

20 Q. Okay. Have you done any analysis
21 to determine whether chains or independents
22 generate more suspicious orders?

23 A. Have we done specific analysis?

24 No.

1 Q. Okay. And what are you not saying
2 in that answer?

3 A. No, we've not done specific
4 analysis.

5 Q. Okay. And if you look at 215.

6 A. Yes.

7 Q. It indicates -- never mind.
8 Withdrawn.

9 Can you just talk me through a
10 couple of the terms? National account alternate
11 care for mail order customer. What are those?

12 A. That would be an alternate care
13 customer, a nursing home, a long-term care
14 facility that is part of a national account. So
15 not an independently-owned free-standing
16 facility or a handful of facilities that are
17 owned. It's part of a larger corporate entity
18 that owns and controls those facilities.

19 Q. Okay. And a mail order customer?

20 A. That would be a customer that we
21 supply to that fills mail order prescriptions
22 for a PBN.

23 Q. Okay. So that would be like
24 Caremark or --

1 A. Exactly.

2 Q. And do you do any audit of their
3 compliance efforts?

4 A. No. But we manage the thresholds
5 for all the facilities that they purchase
6 controls from us.

7 Q. And do they give you, in the same
8 way national chains do, all of their data?

9 A. Yes.

10 Q. And that's always been the case?

11 A. We don't have some of the large
12 mail order pharmacies that we had when I came on
13 board. And some of the large ones we have now
14 we didn't have when I came on board. So for the
15 ones that we have now, we have received that
16 data since I've been in the role.

17 Q. Okay. And is the same data
18 provision true of all these other national
19 accounts, your warehouse accounts, managed care
20 accounts, PPO, HMO, all are the same
21 relationship where you get all of that data?

22 A. Yes.

23 Q. Okay. What is the customer data
24 management and compliance team?

1 A. CDMC is the group that maintains
2 the master non-purchasing customer data.

3 Q. Say that one more time.

4 A. They maintain all of the customer
5 information that's not sales data specific.

6 Q. So payment terms and --

7 A. Yes.

8 Q. Okay. You don't play any role in
9 that?

10 A. No.

11 Q. And have you done for those other
12 national accounts -- just going back to the same
13 question of how many suspicious orders they
14 generate. Do you see any trends in those
15 accounts?

16 A. The alternate care?

17 Q. Just all of these national --
18 these bundle of national accounts. Have you
19 observed anything with respect to their
20 suspicious orders?

21 A. I will tell you that the large
22 national account chains are very focused on
23 their numbers, and the numbers continue to come
24 down. They're very choosy over what control

1 scripts they fill.

2 Q. And has that been true throughout
3 your period or something that has kicked in?

4 A. It's been true since I've been in
5 the role.

6 Q. I'm just going to give you a title
7 of the document while Natalie is pulling that.

8 Suspension of Controlled
9 Substances Sales. Is that a report title you're
10 familiar with?

11 A. Not a report.

12 Q. What?

13 A. Not a report. I assumed it was
14 going to be an SOP that we were going to --

15 Q. No.

16 A. I'm not familiar with a report
17 that says that, Suspension of Controlled
18 Substances Sales.

19 - - -

20 (Montana-Cardinal Exhibit 22 marked.)

21 - - -

22 Q. So Exhibit 22 is CAH_MTAG_383.

23 And I just want you to look at Bates Number 386.

24 So there's a series of bulleted

1 items, I think, in the second box on your left.

2 A. Yes.

3 Q. The only question there: Do you
4 look at the same factors for chain pharmacies,
5 independents, and your other national accounts?

6 A. Yes.

7 Q. All of those factors are looked at
8 for all of your accounts?

9 A. Yes.

10 Q. Okay. You indicated earlier
11 that -- I don't remember what the term was, but
12 the data that gives you access to prescriptions
13 that are covered by insurance, the switch?

14 A. Yes.

15 Q. So you get that data from an
16 independent source, or do you get it from your
17 pharmacy customers?

18 A. The pharmacy customers agree for
19 us to receive the data. Then we get the data
20 from the switch.

21 Q. Okay. And what do you use that
22 data for?

23 A. We use that data to see for the
24 data that is included what the dispensing

1 volumes look like for those pharmacies.

2 Q. Okay. But it excludes cash
3 payments. So how do you know how much of a
4 pharmacy's dispensing volume is in cash?

5 A. When we do the look-under-the-hood
6 visit, that's one of the reports we have them
7 run, is what percentage of the scripts are cash.

8 Q. Okay. And is that something the
9 customer provides or you're able to verify?

10 A. The customer runs the report for
11 us.

12 Q. Okay. And you only get it for
13 those customers for which you do the full site
14 visit?

15 A. Yes.

16 Q. We talked about customer zone
17 earlier.

18 A. Yes.

19 Q. Can you just explain what a
20 customer zone is?

21 A. So if you think of the concept of
22 the bell curve, it's taking a bell curve and
23 putting it into a nine-box grid, and then
24 placing the customers in those various grids,

1 similar to the concept of the bell curve;
2 normal, within a range, high on the far right,
3 high on the far left -- low on the far left I
4 should say. It's that concept.

5 Q. Okay. And so how do you determine
6 for each customer class or type of account where
7 they fit in the bell curve?

8 A. So we look at the national data
9 that we purchased to allow us to understand what
10 that curve looks like. And then we'll take the
11 customer's purchasing data and potentially the
12 dispensing data if we do a visit or if they're
13 on the data feed, and then plot them accordingly
14 and see how they compare to their peer.

15 MS. SINGER: All right.

16 CAH_MTAG_1728. I will make this our
17 last.

18 - - -

19 (Montana-Cardinal Exhibit 23 marked.)

20 - - -

21 BY MS. SINGER:

22 Q. So is this a document you
23 recognize?

24 A. Yes.

1 Q. Is that currently used?

2 A. Yes.

3 Q. And can you read the title?

4 A. "QRA SOM Customer Analytics
5 General Work Instructions."

6 Q. Okay. What is a CIM -- and the
7 profit leader program are both referred to in
8 the document.

9 A. Those -- CIM stands for Cardinal
10 Inventory Manager. And it's a software that we
11 can provide to pharmacies. It helps them
12 maintain appropriate inventory levels of their
13 prescription medication on the shelf.

14 Q. Okay. And then the profit leader
15 program?

16 A. It is a program that utilizes that
17 switch data that we talked about to help the
18 customers run their business.

19 Q. Okay. And that's what generates
20 the score or allows you to generate the score
21 that you were talking about earlier?

22 A. It allows you to generate the
23 score off of that data. But we also generate
24 the score off the purchase data from us as well.

1 Q. Okay. And so how does the score
2 play out in your compliance efforts?

3 A. The score dictates what level of
4 due diligence that we need to do for that
5 specific customer. So each of the categories we
6 had talked about earlier, the control
7 percentage, oxy/hydro percentage, those all have
8 a score. And that score then dictates the zone
9 from -- do we visit you, do we LV TAC you, do we
10 cut you off.

11 Q. So will a customer's profile
12 indicate its zone?

13 A. It does, but not in the -- not in
14 the scoring profile of it. But you can -- you
15 can see what's on the volume based on the layers
16 of which you dig into the data.

17 Q. Meaning if you're looking at the
18 data, you'll be able to identify what the zone
19 is?

20 A. There are views of the data that
21 show you what zone the customer would fall into
22 for that drug family.

23 Q. Okay. And will the score also be
24 evident from the profile?

1 A. The score will be, yes.

2 Q. Okay. And is there a score per
3 drug family?

4 A. Yeah. There's a score per
5 objective criteria; control, percentage,
6 oxy/hydro percentage, the mix within oxy, the
7 mix within hydro, those.

8 Q. Which cut across drug families?

9 A. Exactly.

10 Q. Okay. And it says in there that
11 CVS and Kroger are subject to a limited number
12 of objective criteria?

13 A. Yes.

14 Q. Why is that?

15 A. Because CVS and Kroger, while they
16 supply us with the data, they self warehouse III
17 through Vs. So they're not buying those from
18 us, so that purchase score is not going to
19 reflect the drugs that aren't coming through us.

20 Q. Okay. And it indicates at 1733
21 that you review historical data going back three
22 months up to six months. Why those periods?
23 Why not longer?

24 A. That's kind of the standard

1 starting time frame for the analyst. But when
2 we get into like an LV TAC situation, we can
3 look at multiple years' worth of data.

4 Q. Okay. And that's -- never mind.

5 And due diligence data info only
6 goes back 12 months?

7 A. No. It goes back further than
8 that.

9 Q. Okay. So that's incorrect or
10 outdated?

11 A. No. It's just saying evaluate the
12 last 12 months. But you could have more data
13 than that.

14 Q. Okay. So the decision not to go
15 back further in looking at the order data or the
16 due diligence information, is that an
17 efficiency, kind of time savings?

18 A. No. It's more about getting the
19 current view of the customer. And you could
20 have three site visits. You can't base your
21 decision off a site visit that's three years
22 old. You need to look at the most current
23 version of the site visit that took place.

24 Q. Okay. 1734 talks about monthly

1 drug distribution by strength.

2 What's that?

3 A. I'm sorry. Where are you looking?

4 Q. 1734.

5 A. Okay. Gotcha.

6 Q. What is that used for?

7 A. Each of the controlled substances
8 that we monitor and set thresholds for, you've
9 got the ability within that controlled substance
10 family to dig in and see what the trending is of
11 the individual strengths within that drug
12 family.

13 MS. SINGER: Okay. Can I take two
14 minutes and just make sure I've looked
15 at everything? I'm going to step out
16 for one second.

17 (Recess taken.)

18 BY MS. SINGER:

19 Q. A couple of cleanup questions.

20 So Cardinal provided us with data
21 on the suspicious order reports for Montana
22 which we talked about. I know you don't have an
23 independent knowledge of that, but it basically
24 runs from 200 to 100 a year from 2013 forward.

1 What does that tell you about the
2 likelihood of suspicious order volume pre-2013?
3 Is there any inference you can draw?

4 A. I don't think it would be fair for
5 me to try to not knowing what the customer base
6 looked like, what the review process was, what
7 the threshold setting methodology was at that
8 point in time.

9 Q. Does zero strike you as unlikely
10 to be justified?

11 A. I honestly can't say justified or
12 not. I would have to understand how they were
13 doing, what they were doing for who the
14 customers were to be able to say if that made
15 sense or not.

16 Q. Can you imagine a customer in a
17 state not generating a single suspicious order
18 in a year, or all customers in a state not
19 generating a single suspicious order? I mean as
20 a professional.

21 A. I know that the sound of it would
22 seem easy to make that distinction. Again, I
23 just don't know what information they were
24 using, what their customer base looked like. It

1 wouldn't be fair for me to make that statement.

2 Q. Since you've been in your
3 position, have you seen a statement in which
4 there hasn't been a suspicious order during a
5 year?

6 A. Not that I recall.

7 MS. SINGER: So you know what?
8 It's been a long day. There's some
9 cleanup questions I could ask. But,
10 Jen, I will bother you with them and
11 deal with them on the side to the extent
12 that there's anything important.

13 MS. WICHT: Okay.

14 MS. SINGER: Thank you very much.

15 THE WITNESS: Thank you.

16 MS. SINGER: I really appreciate
17 it.

18 (Signature not waived.)

19 - - -

20 Thereupon, at 6:09 p.m., on Wednesday,
21 September 27, 2018, the sworn testimony was concluded.

22 - - -

23

24

1 CERTIFICATE

2 STATE OF OHIO :

SS:

3 COUNTY OF FRANKLIN :

4

5 I, TODD CAMERON, do hereby certify that I
6 have read the foregoing transcript of my testimony
7 given on September 26, 2018; that together with the
8 correction page attached hereto noting changes in form
9 or substance, if any, it is true and correct.

10

TODD CAMERON

11

12 I do hereby certify that the foregoing
13 transcript of the examination of TODD CAMERON was
14 submitted to the witness for reading and signing; that
15 after he had stated to the undersigned Notary Public
16 that he had read and examined his examination, he
17 signed the same in my presence on the _____ day of
18 _____, 2018.

19

20 _____
NOTARY PUBLIC - STATE OF OHIO

21

22 My Commission Expires:

23 _____, _____.
24

1 CERTIFICATE

2 STATE OF OHIO :

SS:

3 COUNTY OF FRANKLIN :

4 I, Carol A. Kirk, a Registered Merit Reporter
5 and Notary Public in and for the State of Ohio, duly
6 commissioned and qualified, do hereby certify that the
7 within-named TODD CAMERON was by me first duly sworn to
8 testify to the truth, the whole truth, and nothing but
9 the truth; that the sworn testimony then given by him
10 was by me reduced to stenotype in the presence of said
11 witness; that the foregoing is a true and correct
12 transcript of the sworn testimony so given by him; that
13 the sworn testimony was taken at the time and place in
14 the caption specified and was completed without
15 adjournment; and that I am in no way related to or
16 employed by any attorney or party hereto or financially
17 interested in the action; and I am not, nor is the
18 court reporting firm with which I am affiliated, under
19 a contract as defined in Civil Rule 28(D).

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IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Columbus, Ohio on
this 8th day of October 2018.

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CAROL A. KIRK, RMR

NOTARY PUBLIC - STATE OF OHIO

My Commission Expires: April 9, 2022.

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Highly Confidential - Todd Cameron

1 DEPOSITION ERRATA SHEET

2 I, TODD CAMERON, have read the transcript
of my deposition taken on the 26th day of
3 September 2018, or the same has been read to me. I
request that the following changes be entered upon the
4 record for the reasons so indicated. I have signed the
signature page and authorize you to attach the same to
5 the original transcript.

6 Page Line Correction or Change and Reason:

7	_____	_____	_____
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24	Date _____	Signature _____	